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The newsletter of Ireland's focal point to the EMCDDA

Alcohol diary interactive tables
See page 10

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Drug-related deaths in Ireland, 2004–2013

The latest figures from the National Drug-Related Deaths Index (NDRDI) show that a total of 679 deaths in Ireland during 2013 were linked to drug use. These figures are contained in a recent NDRDI report which provides information on deaths from poisoning, trauma or medical causes in which drugs were a factor in the fatality during the period 2004–2013.[1]

Speaking at the launch of NDRDI's latest web update on 15 December 2015, Minister of State for Drugs, Aodhán Ó Ríordáin, expressed his concern about the rising number of deaths, the increase in heroin deaths and, in particular, heroin deaths linked to injecting. He said the government has taken steps to prevent these deaths by expanding needle exchange services and making naloxone for the treatment of opiate overdose more widely available.

Some of the key findings of the report are:

- Alcohol was implicated in 1 in 3 (137) of all poisoning deaths in 2013, and alcohol poisoning alone claimed one life each week.
- 234 people (60%) died in 2013 because they took a mixture of drugs.
- Heroin deaths increased in 2013 for the first time since 2009. In 2013, 86 poisoning deaths (one in five) were heroin-related and in almost 50% of these deaths, the user was injecting at the time.

1 Health Research Board (2015) *Drug-related deaths and deaths among drug users in Ireland: 2013 figures from the National Drug-Related Deaths Index.* Dublin: Health Research Board. www.drugsandalcohol.ie/24676

Minister of State for Drugs, Aodhán Ó Ríordáin, Ms Ena Lyn, author, Dr Graham Love, CEO, HRB and Dr Suzi Lyons author at the launch of the Drug-related deaths in Ireland, 2004–2013 report in December.

Drug-related deaths *(continued)*

Table 1 Number of poisoning and non-poisoning deaths, by year, NDRDI 2004–2013 (N=6,002)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All deaths	432	505	554	622	628	658	609	657	658	679
Poisonings (3,519)	267	300	325	389	386	374	342	388	361	387
Non-poisonings (2,483)	165	205	229	233	242	284	267	269	297	292

The NDRDI reports on poisoning deaths (also known as overdoses), where the drug, or combination of drugs, actually poisoned the person, and on non-poisonings, which are deaths as a result of trauma (such as hanging) or medical reasons (such as cardiac events) among people who use drugs. The latest figures on both poisoning and non-poisoning deaths are presented in Table 1.

Poisoning deaths in 2013

The annual number of poisoning deaths increased from 361 in 2012 to 387 in 2013. As in all previous years, males accounted for the majority of deaths (68% in 2013). The median age was 41 years.

Almost two thirds (60%) of all poisoning deaths involved more than one drug (polydrug use):

- Alcohol was involved in 35 per cent of poisoning deaths in 2013, making it the drug most commonly involved in poisoning deaths. Alcohol alone was responsible for 15 per cent of all deaths.
- Methadone was implicated in a quarter of poisonings in 2013. The majority of deaths (94%) in which methadone was implicated were polydrug poisonings.

Minister of State for Drugs, Aodhán Ó Ríordáin at the launch of the Drug-related deaths in Ireland, 2004–2013 report in December.

Contents

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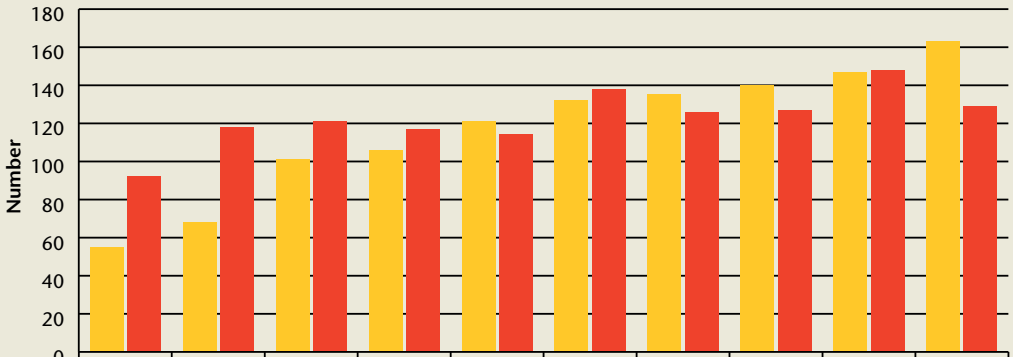
Drug-related deaths *(continued)*



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Medical	55	68	101	106	121	132	135	140	147	163
Trauma	92	118	121	117	114	138	126	127	148	129

Figure 1: Non-poisoning deaths among drug users, NDRDI 2004–2013 (N=2,398)

Two fifths (41%) of poisonings in 2013 involved benzodiazepines, almost all (99%) of which involved polydrug use.

The number of poisoning deaths in which heroin was implicated increased for the first time since 2009, being a factor in 22 per cent of poisoning deaths in 2013:

- Over two-fifths (42%) of people for whom heroin (injecting or smoking) was implicated in their death were not alone at the time they took the drug.
- Half (49%) of those who died from a heroin-related death were known to be injecting at the time of their death.
- Three in five (62%) of deaths in 2013, where heroin was injected, occurred in a private dwelling.

Over two fifths (43%) of those who died of a poisoning death in 2013 had a history of mental health illness.
The number of deaths involving antidepressants and other prescription drugs has increased. Citalopram is the most common antidepressant implicated in these deaths, being implicated in over one fifth (22, 22.4%) of individual deaths involving antidepressants in 2013.

Non-poisoning deaths in 2013

The number of non-poisoning deaths recorded among drug users decreased slightly, from 295 in 2012 to 292 in 2013 (Figure 1). In 2013, males accounted for 77 per cent of all non-poisoning deaths. Almost two fifths (38%) of those who died of non-poisoning had a history of mental illness.

Deaths owing to hanging continue to be the main cause of non-poisoning deaths, accounting for 25 per cent of all non-poisoning deaths in 2013 (Figure 2). In 2013, almost two thirds (59%) of deaths owing to hanging were among people who had a history of mental health illness.

The most common medical causes of death were cardiac events, accounting for 18 per cent of all non-poisoning deaths in 2013 (Figure 2).

The data show that a younger cohort died from traumatic causes (median age 34 years) in comparison to medical causes (median age 47 years).

(Ena Lynn)

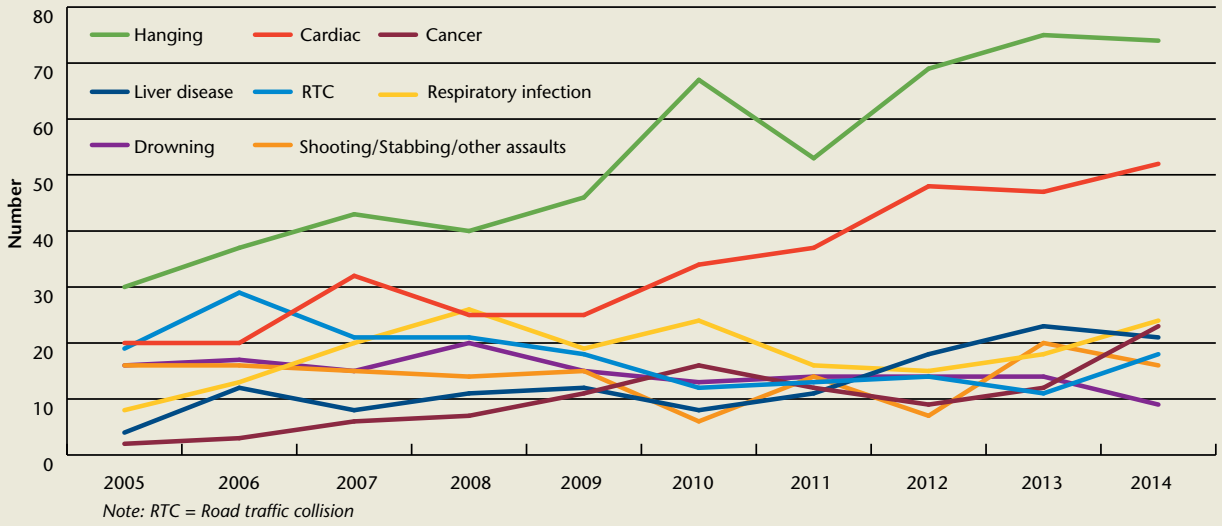


Figure 2: Non-poisoning deaths among drug users, by main type of death, NDRDI 2004–2013 (N=1,748)

Public Health (Alcohol) Bill 2015

Minister for Health Leo Varadkar launched the Public Health (Alcohol) Bill on 8 December 2015.[1] The Bill addresses alcohol as a public health issue for the first time and it aims to reduce alcohol consumption in Ireland to 9.1 litres of pure alcohol per person per annum by 2020 and to reduce alcohol-related harm.

Main provisions of the Bill

The main provisions of the Bill include minimum unit pricing, health labelling of alcohol products, the regulation of advertising and sponsorship of alcohol products, structural separation of alcohol products in mixed trading outlets, and the regulation of the sale and supply of alcohol in certain circumstances.

Minimum unit pricing

Minimum unit pricing will tackle the sale of cheap alcohol particularly in the off-trade sector and the price will be set at 10 cent per gramme of alcohol. This means that a 750ml bottle of wine with an ABV (alcohol by volume, alc/vol) of 12.5 per cent cannot be sold for less than €7.50. This is aimed at those who drink in a harmful and hazardous manner and its effects will be felt most keenly by high-risk drinkers. Research by the University of Sheffield has estimated that this measure alone could save €1.7 billion over 20 years by reducing healthcare costs, crime and policing, reducing absenteeism, and improving quality of life.[2]

Health labelling

Compulsory health labelling will mean that alcohol containers are required to carry information about the amount of alcohol measure in grammes and the calorie count; health warnings, including one for pregnancy; and a link to a public health website (to be set up by the HSE). On- and off-licences will be required to display a notice with health warnings indicating that grammes and calorie content for 'poured drinks' can be found in a document available upon request.

Alcohol advertisements

The Bill restricts alcohol advertisements so that they can only give specific information about the product. This will mean that advertisements will be less likely to glamourise alcohol or make it appealing to children. The Bill bans advertising near schools, early years services, playgrounds and public transport. Alcohol-related advertisements will be restricted to films with an '18 and over' certificate and there will be a 9.00 pm broadcasting watershed for alcohol advertisements. Advertising will be prohibited in sports grounds for events where the majority of competitors or participants are children, and merchandising of children's clothing is also restricted.

Structural separation

Structural separation in mixed trading outlets means that alcohol must be stored either in a separate area of the shop through which customers do not have to pass to buy 'ordinary' products, or in a closed storage unit(s) which contains only alcohol products. Alcohol products behind check-out points will need to be concealed.

Promotions

Promotions whereby alcohol products are sold at a reduced price or free of charge will be restricted or banned; these include promotions targeted to a particular category of persons, and 'happy hour' type promotions.

Enforcement and review

The provisions in the Bill will be enforced by authorised officers of the HSE. The provisions will be reviewed after three years from commencement to examine their effectiveness.

(Deirdre Mongan)

1 Public Health (Alcohol) Bill 2015, Bill Number 120 of 2015. Retrieved 21 December 2015 http://www.oireachtas.ie/viewdoc.asp?DocID=30442&&CatID=59

2 Angus C, Meng Y, Ally A, Holmes J and Brennan A (2014) *Model-based appraisal of minimum unit pricing for alcohol in the Republic of Ireland.* Sheffield: ScHARR, University of Sheffield. http://www.drugsandalcohol.ie/23904/

Regulating sponsorship by alcohol companies of major sporting events

In 2013 the Irish government established a working group to examine the regulation of sponsorship by alcohol companies of major sporting events. The working group reported its findings in December 2014.[1]

Comprised of representatives from several government departments, the working group was asked to 'consider the value, evidence, feasibility and implications (including the public health consequences for children and young people and the financial impact on sporting organisations) of regulating sponsorship by alcohol companies of major sporting events' and 'to consider alternative sources of funding for sporting organisations to replace potential lost revenue arising from any such regulation'. Following an initial analysis of the relevant available information and identifying information gaps, the group formulated a set of questions with a view to gathering evidence to facilitate a complete understanding of the issue. These questions were sent to key stakeholders. Main findings of the group were as follows.

Impact of sports sponsorship on alcohol consumption

Sports sponsorship is usually part of an integrated marketing approach, making it difficult to untangle the specific impacts each marketing activity has and to draw conclusions about the potential impact of restrictions on alcohol sponsorship of sports events. It is generally accepted that the share prices of companies react positively to sports sponsorship, while customers operate on the principle that if a brand is good enough to back a much-loved sport, then it's good enough for them.

Regulating alcohol sponsorship *(continued)*

There is high-quality international evidence demonstrating a link between general marketing and alcohol consumption. A systematic review of 13 longitudinal studies of 38,000 young people aged 10–21 years concluded that 'alcohol marketing increases the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol'.[2] The alcohol industry disputes the link between marketing and increased consumption, claiming that marketing simply acts as a brand differentiator.

The evidence with regard to links between sports sponsorship and alcohol consumption is limited. Research from Australia and New Zealand has shown that sportspeople receiving alcohol industry sponsorship at a team or club level are more likely to be hazardous drinkers. The working group acknowledges that there is a lack of Irish research measuring the impact of sports sponsorship by alcohol companies, and it is not clear to what extent social norms or accepted cultural behaviour in Irish society influence drinking behaviour, compared to the alcohol industry.

Given the lack of evidence with regard to impact, the working group looked at what other countries had done regarding alcohol sponsorship of sport. In France the Loi Evin has imposed a complete ban on alcohol sponsorship of sporting events. This law made it impossible for American brewer Anheuser-Busch to sponsor the 1998 FIFA Football World Cup in France despite heavy lobbying of the French government. There has been a 20 per cent decline in alcohol consumption in France since the law came into effect in 1990 but this downward trend began in the 1960s. It is not clear how much of the decrease can be attributed to the Loi Evin as opposed to other factors.

Value of alcohol sponsorship to sporting organisations

A 2011 report for the Drinks Industry Group of Ireland estimated that the value of sports sponsorship was €35 million; this was regarded as a conservative figure.[3] The value of alcohol sponsorship is largely invested in the GAA (Gaelic Athletic Association), FAI (Football Association of Ireland) and IRFU (Irish Rugby Football Union). The major sporting organisations which presented submissions to the working group stated that the loss of the funding through sports sponsorship would have a detrimental impact on local clubs and on their capacity to offer development programmes for young people. The FAI and the IRFU expressed concerns that additional restrictions could jeopardise their chances of participating in international tournaments. There were alternative views that restrictions might not harm sporting organisations; it was noted that the Loi Evin had not prevented France from hosting both soccer and rugby World Cups.

Alternative sources of sponsorship for the sports sector

Conflicting views were given regarding alternative sources of sponsorship. While some submissions claimed that alcohol sponsorship could be gradually replaced by revenue from other commercial companies, it was also stated that even if alternative sponsors could be found, these organisations would be unlikely to pay the premium price that alcohol sponsors do, which would lead to a decrease in sponsorship revenue.

The experience of the GAA in securing sponsorship unrelated to alcohol companies was cited as an example that alternative sponsors can be found. The Australian government's willingness to replace alcohol sponsorship with state funding was also mentioned: it had committed to providing A$25 million over four years for a 'community sponsorship fund' as an alternative for sporting and cultural organisations. The working group concluded it was not possible to answer this question, but noted that if the current economic recovery continues, other commercial sources of revenue might become available.

Options for regulation which fall short of a ban

The report examines the features of successful regulatory schemes, namely volume restrictions, content restrictions and an effective system of regulation.

- Imposing volume restrictions on alcohol marketing can be successful if the proposed bans are not merely symbolic but contribute substantially to the total volume of alcohol advertising to which adolescents are exposed, and if no significant substitution effects arise such as price reductions or marketing shifts to other media.
- Limiting exposure to attractive advertisements by adjusting their content can be an important restriction. In France advertisements can only contain product information, such as the name of the product, percentage alcohol by volume, origin, name and address of manufacturer, and consumption mode of the product.
- Regulation needs a clear legislative framework. Effective regulation requires pre-screening of advertisements, a complaints system, effective sanctions, and an independent monitoring system that routinely monitors the content and volume of alcohol marketing.

Conclusions

The working group could not reach clear evidence-based conclusions on the actual costs and benefits of further regulation of alcohol sponsorship of sporting events. It concluded that the most useful approach would be to identify a number of options ranging from maintaining the status quo to banning sponsorship of major sporting events by alcohol companies, and seek to elaborate the likely advantages and disadvantages of each approach, to inform the government's consideration of the matter.

(Deirdre Mongan)

1 Department of the Taoiseach (2014) *Report of the working group on regulating sponsorship by alcohol companies of major sporting events.* http://www.taoiseach.gov.ie/eng/Work_Of_The_Department/Social_Policy_and_Public_Service_Reform/Report_of_the_Working_Group_on_Regulating_Sponsorship_by_Alcohol_Companies_of_Major_Sporting_Events.pdf

2 European Health and Alcohol Forum (2009) *Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? – a review of longitudinal studies.* http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf

3 Foley A (2011) *The contribution of the drinks industry to tourism, festivals and sport.* Drinks Industry Group of Ireland. http://www.drugsandalcohol.ie/15823/

Adolescents' exposure to alcohol marketing

Alcohol Action Ireland commissioned the Health Promotion Research Centre at NUI Galway to undertake research on the extent and nature of Irish adolescents' exposure to alcohol marketing and to determine the relationship between exposure to alcohol marketing and alcohol drinking behaviour.[1]

The study population consisted of 686 secondary school children aged 13 to 17 years (52.6% boys, 47.4% girls), from 16 schools in counties Galway, Dublin and Cork. Between April and May 2013 students were asked to complete a questionnaire on their opinions, health behaviours, family, leisure activities, and exposure to alcohol marketing, and to complete an alcohol marketing diary to record all alcohol marketing they encountered during one week day and one weekend day. They were asked to note the alcohol brand being advertised, the media channel through which it was presented, where and when it was seen or heard, and how appealing the advertisement was to them.

Results

Almost two thirds of the students reported that they consumed alcohol (boys 62.5%, girls 65.4%). This was more common among 16–17-year-olds (74.6%) than among 13–15-year-olds (53.5%). Among those who drank, 23.6 per cent of 13–15-year-olds and 51.4 per cent of 16–17-year-olds reported being drunk in the past month.

Girls were more likely than boys to report online exposure to alcohol advertising (Table 1). A number of different types of online exposure were measured. In the previous week 72 per cent saw an online advert/pop-up for an alcohol product, 15.4 per cent received an online quiz about alcohol or drinking, 35 per cent were invited to 'like' an alcohol brand, 29.7 per cent were invited to 'like' an event sponsored by an alcohol brand, and 21.4 per cent were invited to go to an event sponsored by an alcohol brand. Younger children were as exposed as older children to alcohol advertisements. Boys were more likely to report that the last sports event they attended was sponsored by an alcohol brand and to own alcohol-branded merchandise. Children reported to have seen a mean of 7.4 alcohol advertisements in the week prior to the survey (boys 8.2, girls 6.5). Those aged 13–15 years reported seeing more advertisements than 16–17-year-olds (7.6 vs 7.2). Overall, 56 per cent of children reported seeing more than four advertisements on a weekday and 54 per cent reported seeing more than four advertisements on a weekend day.

Logistic regression analysis showed that increased exposure to alcohol marketing increased the risk of children engaging in the drinking behaviours examined (drinking alcohol, binge drinking, drunkenness, intention to drink in the next year), compared to children who were not exposed to alcohol marketing. In general, the higher the number of exposures (alcohol advertisements), the more common the drinking behaviours became. Owning merchandise, which may be described as engagement with alcohol brands beyond passive exposure, was the strongest predictor of alcohol behaviours.

Conclusions

It is clear that Irish children are exposed to large volumes of alcohol marketing, which increases their likelihood of drinking alcohol and engaging in risky drinking behavior, which is consistent with results from research conducted internationally. Given young people's vulnerability to alcohol-related harm, there is a definite need for immediate and effective action on alcohol marketing regulation. These results indicate that the current Irish regulatory system fails to protect children from exposure to alcohol marketing.

The proposed Public Health (Alcohol) Bill 2015 is an important first step in this regard as alcohol marketing will be regulated by way of a statutory code rather than the existing system of self-regulation. There will be restrictions on advertising of alcohol on television and radio, in cinemas and via outdoor media. However, the bill includes no provisions dealing with online marketing, which is an important element of the alcohol marketing mix in Ireland and needs to be regulated.

(Deirdre Mongan)

1 Fox K, Kelly C and Molcho M (2015) *Alcohol marketing and young people's drinking behaviour in Ireland.* Galway: National University of Ireland Galway. http://www.drugsandalcohol.ie/24854/

Table 1: Percentage of students reporting exposure to various types of alcohol marketing, 2013

	Online exposure	Non-online exposure	Alcohol branded merchandise ownership	Last sports event attended was sponsored by an alcohol brand	Last music event attended was sponsored by an alcohol brand
All students	77.2	90.9	61.2	18.3	16.1
Boys	74.0	90.5	71.4	22.8	15.4
Girls	80.8	91.3	50.0	13.2	16.9
13–15-year-olds	74.9	90.7	63.9	18.6	14.6
16–17-year-olds	79.6	91.0	58.5	18.0	17.6

Preventing alcohol-related harm: what communities can do

In February 2013 Galway Healthy Cities Alcohol Forum launched its strategy to prevent and reduce alcohol-related harm in Galway City between 2013 and 2017.[1] The Forum includes representatives from HSE West, the Western Drugs and Alcohol Task Force, Galway–Roscommon Education and Training Board, An Garda Síochána, Galway City Council, Galway City Public Participatory Network and National University of Ireland Galway.

Under the Prevention 'pillar' in the strategy, and in pursuit of the strategic action – to 'communicate effective measures to prevent and reduce alcohol-related harm and the benefits of undertaking these measures' – the Forum recently published a booklet presenting the scientific evidence for various alcohol policies in order of effectiveness, and suggesting actions the community can undertake in relation to each policy.[2]

1. Supply

Supply policies include reducing affordability, availability and marketing. Increasing the price of alcohol reduces alcohol consumption and alcohol-related harm. The main alcohol pricing policies are alcohol taxation and minimum unit pricing. Policies to reduce availability include limiting the number of outlets licensed to sell alcohol, limiting the hours of sale, setting a minimum purchase age, preventing sales to intoxicated people, and limiting drinking in public places. To reduce children's exposure to marketing and resultant harm, statutory regulation is needed with a monitoring system that is totally independent, clear to all, accountable and involves young people.

Community action opportunities

- Advocate for minimum pricing policy as a matter of urgency.
- Examine the potential to reduce very cheap discounts, through voluntary agreements with alcohol sellers, while waiting for the Public Health (Alcohol) Bill 2015 to be enacted.
- Map the number, type and density of outlets selling alcohol in the community.
- Increase enforcement of alcohol laws through a systems approach regarding youth access, distance sales, secondary purchasing, serving intoxicated customers and drink–driving.
- Limit drinking in public places through local bye-laws.
- Examine current licensing laws and propose changes to benefit the community's safety.

2. Early intervention and treatment

There is a strong body of high-quality evidence showing that effective intervention by the health sector can prevent and reduce alcohol-related harm. Brief alcohol interventions are particularly effective among hazardous and harmful drinkers who are not seeking treatment. Psychosocial counselling for treatment-seeking patients has the strongest evidence of effectiveness and can be supported by pharmacological interventions. The precise combination of treatment depends on the severity of the problem, the goals of treatment, and the patient's preferences.

Community action opportunities

- Provide training, support and incentives for alcohol screening and brief advice in primary care, emergency care, general hospitals and third-level colleges.
- Identify and develop local pathways for treatment service at the individual and family level.
- Ensure a broad base of treatment options and evidence-based interventions are available within the community.
- Ensure the local community are aware of how to access alcohol treatment services and are encouraged to do so.

3. Prevention and awareness

Prevention policies tend to focus on information, education and persuasion programmes. While information and education are important for the public to understand the risks associated with drinking, prevention policies have little value in reducing alcohol-related harm if implemented alone.

Community action opportunities

- Increase the awareness of the range of alcohol-related problems in the community.
- Promote the benefits of reducing alcohol-related problems – improved community safety and better quality of life.
- Increase the understanding of the large evidence base of what works and what does not work in reducing alcohol-related harm.
- Ensure the local community understand that protecting children is everyone's responsibility and how best to achieve this.

4. Monitoring and evaluation

It is important that a community action plan has clear outcome measures against which success can be monitored. A monitoring system should be put in place at the outset to track progress.

Community action opportunities

- Undertake a community audit; identify needs and priorities for the community.
- Build awareness within the community so that everyone has a role to play.
- Put a monitoring system in place.
- When planning to deliver evidence-based interventions, ensure independent evaluation takes place to build the knowledge base in Ireland.
- Ensure the community alcohol action group, representing the collective process, has regular roundtable discussions with all relevant sectors in the community to review progress and plan future actions.

(Deirdre Mongan)

1 *Galway City strategy to prevent and reduce alcohol-related harm 2013–2017.* http://www.drugsandalcohol.ie/19344/

2 Hope A (2015) *Research evidence to prevent alcohol-related harm: what communities can do in Ireland.* Galway Healthy Cities: Galway City Alcohol Strategy to Prevent and Reduce Alcohol-Related Harm (2013-2017). http://www.drugsandalcohol.ie/24166/

Minimum unit pricing for alcohol: what will it really mean?

The publication of the HRB's National Alcohol Diary report reinforced the case to introduce minimum unit pricing (MUP) for alcohol in Ireland.[1] The recent response of the European Court of Justice's Advocate General re-ignited the debate and was taken by some to suggest that MUP was not going to be legally enforceable. However, the judgement was a little bit more nuanced than that.[2]

What the European Court of Justice's Advocate General actually said was that MUP for alcohol is legal 'on condition that it shows that the measure chosen presents additional advantages or fewer disadvantages by comparison with the alternative measure', in this case, general taxation.

There is compelling international evidence that pricing is one of the most effective ways to reduce alcohol consumption and tackle alcohol-related harm. The World Health Organization (WHO) has made it clear that there is 'indisputable evidence that the price of alcohol matters':[3] if the price of alcohol goes up, alcohol consumption and its related harm goes down. An increase in the price of alcohol through taxation is a general pricing intervention that will reduce alcohol consumption among all drinkers equally and decrease its related harms.

However, MUP is a targeted measure, designed to reduce alcohol consumption among heavy drinkers and harmful drinkers (such as binge drinkers). Cheap alcohol products are favoured by the heaviest drinkers, who generally seek to get as much alcohol as they can for as little money as possible and are most at risk of alcohol-related illnesses and death. In addition, young people, who generally have the least disposable income but the highest prevalence of binge drinking, buy cheap alcohol. An MUP policy stops alcohol being sold at very low prices in the off-trade, particularly supermarkets, where alcohol is frequently used as a 'loss leader' and sold below cost.

MUP is a 'floor price', beneath which alcohol cannot legally be sold, and is based on the amount of alcohol in a product, measured in grammes. One standard drink in Ireland contains 10 grammes of alcohol and an MUP would apply per standard drink. Under an MUP policy of one euro per standard drink,

- a bottle of spirits could not be sold for less than €21,
- a bottle of wine could not be sold for less than €7, and
- a pint of beer could not be sold for less than €2.

The evidence for the benefits of MUP can already be seen in Canada. For example, in British Columbia a 10 per cent increase in the MUP was associated with a 32 per cent fall in wholly alcohol-related deaths, while it also led to reductions in alcohol-related hospital admissions and crime, particularly alcohol-related traffic offences and crimes against the person.[4]

In 2013 the Sheffield Alcohol Research Group (SARG) adapted the Sheffield pricing model for alcohol to Ireland in order to appraise the potential impact of different pricing policies.[5] In the following example from this appraisal, MUP is compared to general taxation.

- For a €1 MUP policy, the estimated per-drinker-reduction in alcohol consumption for the overall population is estimated at 8.8 per cent and equated to an average annual reduction of 57.2 standard drinks per drinker per year. As this is a targeted pricing policy, high-risk drinkers have larger estimated reductions in alcohol consumption as a result of an MUP policy than increasing-risk or low-risk drinkers. For example, the estimated reductions in consumption for a €1 MUP are 15.1 per cent for high-risk drinkers, 7.2 per cent for increasing-risk drinkers and 3.1 per cent for low-risk drinkers.
- The introduction of a 10 per cent (tax) increase on the price of all types of alcohol (cheap and expensive) would decrease alcohol consumption for all drinkers by 5–6 per cent and would affect low-risk, increasing-risk and high-risk drinkers equally.

The Scottish Court of Session has already considered this matter and is of the view that taxation is 'likely to be less effective in achieving the legitimate aims which the minimum pricing measures pursue'.[6] Ireland's MUP model also demonstrates that MUP has additional advantages over a 10 per cent general tax increase on alcohol.

(Jean Long and Brian Cummins)

1 Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey.* Dublin: Health Research Board. http://www.drugsandalcohol.ie/22138/

2 *The Scotch Whisky Association and Others v The Lord Advocate and The Advocate General for Scotland 2015.* http://curia.europa.eu/juris/document/document.jsf?text=&docid=166846&pageIndex=0&doclang=en&mode=req&dir=&occ=first&part=1&cid=210514

3 World Health Organization Europe (2009) *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm.* http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf

4 Stockwell T and Thomas G (2013) *Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol.* An Institute of Alcohol Studies report. http://www.ias.org.uk/uploads/pdf/News%20stories/iasreport-thomas-stockwell-april2013.pdf

5 Angus C, Meng Y, Ally A, Holmes J and Brennan A (2014) *Model-based appraisal of minimum unit pricing for alcohol in the Republic of Ireland.* Sheffield: ScHARR, University of Sheffield. http://www.drugsandalcohol.ie/23904/

6 Petition for judicial review by Scotch Whisky Association & others http://www.scotland-judiciary.org.uk/9/1040/Petition-for-Judicial-Review-by-Scotch-Whisky-Association-And-Others

Alcohol conference and training seminar

The North Dublin Regional Drugs and Alcohol Task Force (North Dublin RDATF) held a two-day alcohol event on 8–9 October 2015.[1] The first day consisted of a conference on the topic 'Alcohol through the ages: from the cradle to the grave'. It was open to all service providers working with people affected by alcohol. Speakers included the following:

- Dr Adam Winstock, consultant addiction psychiatrist and Director of the Global Drug Survey, gave the keynote address.
- Dr Suzi Lyons, Health Research Board, set the national context using routine surveillance data.
- Dr Gerry McCarney from SASSY – Substance Abuse Service Specific to Youth – spoke about alcohol treatment challenges in emergency medicine, and adolescents and alcohol use.
- Aoife Dermody along with Marie Lawless presented the first results from the evaluation of the CARE (Community Alcohol Response and Engagement) community-based intervention, an initiative of the Ballymun Local DATF, which was rolled out in partnership with the North Dublin RDATF and the Fingal/Cabra LDATF.[2] (See separate report on the evaluation of CARE on pp. 20--21 later in this issue.)
- Megan O'Leary from the National Family Support Network presented on the impact of alcohol on the family and carers.
- Monica Hynds and Robert Dunne from Barnados discussed parental alcohol use and the impact on children.
- Dr Winstock discussed physical complications from alcohol, diagnosing dependence and brief screening and interventions.

The second day comprised clinical training for treatment providers and GPs, delivered by the indefatigable Dr Adam Winstock. Topics covered included alcohol assessment, monitoring and management of alcohol withdrawal, and maintaining abstinence with pharmacotherapies. Eighty professionals attended this training.

The main 'learnings' from the two days are summarised below.

- More robust local data on alcohol consumption and help-seeking behaviours are required. Compiling data from easily accessible digital health applications, for example the 'Drinks meter',[3] which incorporates screening and brief intervention tools (including Audit C) and has the potential to gather information on a large number of people within the task force area, could provide meaningful data in relation to alcohol use and assist with the planning of services. The North Dublin RDATF is planning to use this app across a number of services.
- There is value in community-based outpatient alcohol treatment approaches incorporating both medical and psychosocial interventions.
- Alcohol needs to be more strongly emphasised in the new National Drugs Strategy due to be adopted in 2016. Although nationally there is acceptance that marketing, availability and supply are key issues in relation to tackling alcohol problems, there is very little emphasis on treatment despite the level of need.
- Screening and early alcohol interventions need to be provided in order to improve outcomes for service users and to reduce the negative impacts on individuals, families and the wider community. Many primary care providers, i.e. GPs and pharmacists, are well placed to work alongside community-based services to deliver these interventions but they need appropriate training and resources to do so.
- The National Drugs Rehabilitation Framework[4] needs to be updated to include alcohol in a more meaningful way. The HSE and national treatment policies continue to focus mainly on opiates.
- Feedback from clinicians indicates that they feel they are not getting enough training and development opportunities for alcohol treatment, particularly as the emphasis is often on opiate treatment.
- Greater integration is needed between medical professionals, mental health specialists and project/case workers in community-based psychosocial services.
- A minority of service users need alcohol detoxification, and many of these could be safely managed in the community if adequate medical, pharmacological and social support were available.
- The impact of problematic alcohol use on families (i.e. children, adults, parents and service users) should be factored into any strategic planning for alcohol.
- A more targeted focus on prevention and assessment for foetal alcohol syndrome is needed. This should be specifically outlined in the forthcoming National Drugs Strategy.

(Suzi Lyons and Bríd Walsh)

1 For more information see http://www.ndublinrdtf.ie/

2 See Dermody, A and Banka P (2015) *Evaluation of CARE (Community Alcohol Response and Engagement) pilot project: Ballymun, Finglas and North Dublin.* Dublin: Ballymun Local Drugs & Alcohol Task Force /Quality Matters. http://www.drugsandalcohol.ie/24700/

3 See http://drinksmeter.com/

4 See http://www.drugsandalcohol.ie/13502/1/National_Drugs_Rehabilitation_Framework_2010.pdf

National Alcohol Diary Survey data: new interactive tables

HRB National Drugs Library

The HRB launched its strategy for 2016–20 and rebranding on 19 January. As part of the HRB's new strategy the National Documentation Centre on Drug Use has changed its named to HRB National Drugs Library. Our new name and new look website was introduced on the same day as the HRB strategy.

We will continue to develop our online resources and evidence services during 2016 and we'll have details of our plans for the coming years in the next issue of *Drugnet Ireland*.

As part of our ongoing work in making data relating to drug and alcohol use available to those who wish to research this topic, the HRB National Drugs Library recently published interactive tables on data gathered through the 2013 National Alcohol Diary Survey.[1] This survey estimated the personal consumption of, and expenditure on, alcohol among the general population aged 18–75 years living in private households in Ireland. The survey included a comprehensive series of questions on both the rates and patterns of alcohol consumption and on alcohol-related harm, and involved interviewing 5,991 respondents in 3,897 households.

The respondents were randomly selected using a two-stage probability sampling procedure. The survey was completed between July and October 2013, and achieved a household response rate of 67.2 per cent and a within-household response rate of 77.1 per cent. The survey population was weighted by age, gender and regional distribution, to ensure that it mirrored the Central Statistics Office's population estimates for 2013.

The new interactive tables will enable you to search the survey data for information relating to the:

- age at which respondent started drinking alcohol;
- number of respondents who consumed alcohol in the 12 months prior to the survey and in the week prior to the survey;
- number of standard drinks respondents consumed on a typical drinking occasion;
- amount of money the respondents spent on alcohol;
- number of standard drinks typically consumed on a drinking occasion; and
- harms that have resulted from the respondent's own drinking or as a result of other people's drinking.

Use the interactive tables at http://www.drugsandalcohol.ie/national-alcohol-diary-survey/

1 Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey.* Dublin: Health Research Board. http://www.drugsandalcohol.ie/22138/

Politicians call for drug policy reforms

In November 2015 a number of high-profile Irish politicians called for a variety of reforms in drug policy including medically-supervised injecting facilities; decriminalisation of drug use; the adoption of compassion, human rights and equality, community and democratic participation as appropriate platforms on which to think about the drugs problem; and the adoption of a health rather than a criminal justice approach to the drugs problem. Whether this month will be remembered as a turning point will depend on whether and how the debate is taken forward by political parties in the run-up to the 2016 general election, and whether and how the debate is reflected in Ireland's third national drugs strategy, due by the end of 2016.[1]

Minister of State with responsibility for the Drugs Strategy

On 2 November Minister Aodhán Ó Ríordáin gave the keynote address at a meeting of the London School of Economics IDEAS International Drug Policy Project.[2] He outlined his views in favour of two new harm-reduction options.

Medically-supervised injecting facilities

'Addiction is not a choice, it's a healthcare issue. This is why I believe it is imperative that we approach our drug problem in a more compassionate and sensitive way. One of the key things that I aim to achieve during my remaining time in office is the introduction of a medically supervised injecting centre for intravenous drug users. … I have asked officials in my Department to examine proposals for the provision of medically supervised injecting facilities as a response to this issue. This is in line with similar models in Sydney and parts of Europe. … as the recent spike in blood-borne viruses in Dublin was among those who are most likely to avail of supervised injecting facilities, I hope that the introduction of these facilities may reduce the risk of future spikes occurring.'

Decriminalisation

'Since taking up my new role as Minister for Drugs, I have spoken to a lot of people who would like to see a more compassionate approach to those who experience drug problems. Too often those with drug problems suffer from stigma, due to a lack of understanding or public

Politicians call for reform *(continued)*

education about the nature of addiction. This stigma can be compounded for those who end up with a criminal record due to possession of drugs for their own use.

'It is against this background that there is now an emerging debate in Ireland on whether an alternative approach to the possession of small quantities of illicit drugs for personal use should be considered.

'I am in favour of a decriminalisation model, but it must be one that suits the Irish context and it must be evidence-based. I believe that this kind of approach will only work if it is accompanied by timely treatment and harm reduction services, backed up by wrap-around supports which foster recovery – such as housing, health and social care. Above all, the model must be person-centred and involve an integrated approach to treatment and rehabilitation based on a continuum of care with clearly defined referral pathways.'

Joint Committee on Justice, Defence and Equality

On 5 November the Joint Committee on Justice, Defence and Equality of the Oireachtas (Houses of Parliament) released a report recommending 'a harm-reducing and rehabilitative approach to possession of small amounts of illegal drugs'.[3] Following a visit by a delegation representing the Committee to Portugal in mid-2015 and further investigation and deliberation at home, the Committee concluded that there is merit in further exploring the Portuguese model and in examining how it may be adapted for use in an Irish context. The Committee suggested that a health/counselling/treatment approach might be more effective and more appropriate for those found in possession of a small amount of illegal drugs for personal use rather than imposing a criminal sanction resulting in a lifelong criminal record.

Specific recommendations

The Committee:

1. strongly recommended the introduction of a harm-reducing and rehabilitative approach, whereby the possession of a small amount of illegal drugs for personal use, could be dealt with by way of a civil/administrative response and rather than via the criminal justice route;
2. recommended that discretion for the application of this approach should remain with An Garda Síochána/health providers;
3. recommended that any harm-reducing and rehabilitation approach be applied on a case-by-case basis, with appropriately resourced services available to those affected;
4. drew attention to the success of 'informal' interaction with users when referred to the 'Dissuasion Committees' in Portugal and recommended that such an approach should be employed in Ireland;
5. recommended that resources be invested in training and education on the effects of drugs and that appropriate treatment be made available to those who need to avail of same; and
6. recommended that research be undertaken to ensure that the adoption of any alternative approach be appropriate in an Irish context.

Committee on Justice, Defence and Equality – Membership

Member	Party
Deputies	
Niall Collins	Fianna Fáil
Alan Farrell	Fine Gael
Anne Ferris (Vice Chair)	Labour
Seán Kenny	Labour
Pádraig Mac Lochlainn	Sinn Féin
Gabrielle McFadden	Fine Gael
Finian McGrath	Independent
Fergus O'Dowd	Fine Gael
David Stanton (Chair)	Fine Gael
Senators	
Ivana Bacik	Labour
Martin Conway	Fine Gael
Tony Mulcahy	Fine Gael
Rónán Mullen	Independent
Denis O'Donovan	Fianna Fáil
Katherine Zappone	Independent

The President of Ireland

On 12 November Michael D Higgins gave the opening address at CityWide's 20th anniversary conference, held in Dublin, which was entitled 'Our Communities, Our World – A Drugs Policy that Works'.[4] While the President did not comment on drug policy, he did discuss the principles that he believes should underpin and inform public policy. A selection of his comments are reproduced below.

Equality and human rights

'A main theme of my Presidency has been to build an inclusive Republic – one in which all citizens are treated with equal dignity and respect and are empowered to participate in our democracy. As a society we have made progress in realising equality for many groups … If we are to achieve the goal of a true Republic and give expression to the vision of universal human rights, then we must seek out and embrace those of our fellow citizens who are most vulnerable and suffer the greatest exclusion. … drug users and those affected by addiction are often in that position of exclusion and denial of citizenship. They are often regarded as being outside or even below the community of rights-holders in our society. Their addiction – a medical and social condition which causes them suffering and impairment – is used as a basis to dehumanise drug users. That dehumanisation takes the form of stigmatisation and derogatory language; and it leads to a denial of services, a lack of voice, and even, on occasion, is used as a justification for victimisation.'

Communities

'It is often to their community that addicts turn as they seek to reclaim their lost selves and become, once again, engaged citizens with a lifetime of possibility in front of them. For some time now the value of a community approach and active citizenship in supporting those struggling with addiction, and providing a base on which to build effective policy, has been widely recognised.

Politicians call for reform *(continued)*

There can be no doubt about the real merit in allowing individuals to engage and participate in the decisions which affect and shape their communities, and the critical role of communities in ensuring long term sustainable solutions to problems such as drug abuse within our society.'

Participative citizenship and democracy

'As a country we owe a great debt to CityWide who, across the years have reached out to those who struggle to address addiction in their lives and to live creatively and realise their own unique path and endless possibilities. Your work continues to be vital as we work to craft a shared future in which all our citizens are treated with dignity, allowed a voice and a right to participate in society. … CityWide is a valuable and uplifting example of participative citizenship and democracy, reminding us of all that is best about Irish society.'

(Brigid Pike)

1 For an account of Dáil debates on the drugs issue over the past 10 years, see Pike B (2014) Dáil debate on cannabis *Drugnet Ireland* (49): 6–8, http://www.drugsandalcohol.ie/21673/ ; Pike B (2012) Politicians and the drugs debate – six years on *Drugnet Ireland* (41): 10 www.drugsandalcohol.ie/17272/ ; and Pike B (2006) Politicians and the drugs debate *Drugnet Ireland* (19): 16–17 www.drugsandalcohol.ie/11285/

2 Address by Minister Aodhán Ó Ríordáin TD to the London School of Economics IDEAS Forum on 2 November 2015. http://www.drugsandalcohol.ie/24742/

3 Joint Committee on Justice, Defence and Equality (2015, 5 November) *Report of the Committee on a harm reducing and rehabilitative approach to possession of small amounts of illegal drugs* http://www.drugsandalcohol.ie/24750/

4 Opening address at the CityWide 20th Anniversary Conference, Croke Park, Dublin, 12 November 2015. Retrieved on 16 November 2015 http://www.president.ie/en/media-library/speeches/opening-address-of-the-citywide-20th-anniversary-conference

Towards UNGASS 2016

Since Issue 48, Drugnet Ireland *has carried 'Towards UNGASS 2016' as a regular column. It reports on policy initiatives, research and debates launched by the UN, member states and civil society organisations in the lead-up to the UN General Assembly Special Session (UNGASS) on the world drug problem, due to be held in New York on 19–21 April 2016.* www.ungass2016.org

On 14 October 2015 the **International Drug Policy Consortium (IDPC)** held an informal briefing for member states at the UN headquarters in New York. It was entitled ***Preparing for UNGASS 2016: Examining complex drug policy issues***. The briefing was co-sponsored by the United Nations and the Permanent Mission of Switzerland to the UN. In introducing the three contributors, the Swiss ambassador to the UN highlighted the need for drug policies to be based on human rights and public health principles and the importance of considering the full range of linkages between the world drug problem and Agenda 2030.[1]

1. Dr Renata Segura of the **Conflict Prevention and Peace Forum of the Social Science Research Council** highlighted the difficulty of finding common ground between the idealistic approach of minimising the availability of illicit drugs, as advocated by the UN's drug-policy-making body, the Commission on Narcotic Drugs (CND), and the views of some member states and academic civil society, who question how realistic the aspiration of a drug-free world is. She challenged UNGASS 2016 to examine the impact that drug trafficking is having on society, and to analyse the consequences of the current drug control regime.
2. Professor Jeffrey S. Fagan of the **New York-based Columbia Law School** discussed the proportionality of punishment in the context of drug-related offences, focusing in particular on whether or not capital punishment is an effective deterrent to drug use and trafficking. Citing empirical evidence obtained over a five-decade long study, he concluded that the research is clear that the use of the death penalty has no deterrent effect on serious crimes such as murder.
3. Dr Dan Werb of the **Toronto-based International Centre for Science in Drug Policy** highlighted the importance of recognising the inherent limitations of current drug policies in their overall effectiveness related to drug consumption patterns: his analysis of the drug policies of several locations (Vancouver, Switzerland and Mexico) suggested that both liberal and stringent approaches produce very similar results with regard to the age of onset and rate of use for cannabis and cocaine. Among other matters, he discussed the need to re-evaluate the current metrics used to evaluate the effectiveness of drug policies, and urged a broadening of metrics to include a range of indicators based on community health, security, human rights, and development.

Videos of the presentations by the three speakers are available on line at http://idpc.net/blog/2015/10/preparing-for-ungass-2016-examining-complex-drug-policy-issues?utm_source=IDPC+Monthly+Alert&utm_campaign=d08071d8c0-IDPC+November+2015+Alert&utm_medium=email&utm_term=0_d40f46a7df-d08071d8c0-18215073

In November 2015 **United Nations University (UNU)** published ***What comes after the war on drugs – flexibility, fragmentation or principled pluralism?*** UNU is a global think-tank established by the UN General Assembly to contribute, through collaborative research, to helping resolve 'pressing global challenges'. A series of meetings, attended by delegates from more than 50 UN member states and representatives of UN entities and civil society and academic organisations and aimed at 'identifying common ground', examined the relationship between contemporary global drug policy and public health, human rights, development and criminal justice.

Towards UNGASS 2016 *(continued)*

Drawing on these consultations, the authors of the 'policy report', James Cockayne and Summer Walker, have discerned a clear trend heading into UNGASS 2016: member states will largely coalesce around an affirmation of the existing regime, coupled with a call for flexibility in implementing the regime. The USA and some Latin American countries have called for **flexibility** as a way to experiment with new approaches to implementing the existing drug control regime, but other states are likely to treat an agreement on flexibility as an acceptable response to their calls for respect for state sovereignty in setting domestic drug policy, including the use of strong punitive approaches. According to the authors, there is a consequent danger, post UNGASS 2016, that flexibility will lead to policy **fragmentation**.

The authors argue that the key to avoiding fragmentation is to ensure that flexibility is not treated as a code word for unprincipled laissez faire, but instead is embedded in a process of collective drug policy development at the UN, based on a more detailed and holistic analysis by member states and other stakeholders of 'what works' in drug policy interventions. They argue that UNGASS 2016 should be seen not as the end of a conversation about drug policy, but as an opportunity to set up a structured and inclusive conversation between 2016 and 2019, when the current *Political Declaration and Plan of Action* comes to an end, and a new one will likely be adopted. They argue that UNGASS 2016 should initiate a conversation that, though leaving room for states to exercise flexibility and discretion, ensures that their policy choices are guided by three principles:

- protection of human rights,
- promotion of human development, and
- guidance by the best available scientific evidence.

The authors describe this approach as **principled pluralism**. http://i.unu.edu/media/unu.edu/news/72569/UNU_Drug_Policy_Online_Final.pdf

On 12 November 2015 **CityWide Drugs Crisis Campaign** held a conference in Dublin on drug policy reform, seeking to answer three questions:

1. What have we learnt from 20 years' experience of trying to tackle the drugs issue here in Ireland?
2. How can we link our experience in Ireland to the international debate on moving from the 'war on drugs' to a public health and human rights approach?
3. How can we bring together the learning and evidence from the Irish and the international experience to feed into the new Irish National Drugs Strategy?

Speakers in the morning included:

- President of Ireland, Michael D. Higgins (see separate report on pp. 11–12 above)
- Ann Fordham (Executive Director, International Drug Policy Consortium): *The UN General Assembly Special Session on Drugs & the shifting global drug policy landscape*
- José Antonio Gutiérrez Danton *(academic, researcher , community activist): International drugs policy and the 'War on Drugs' – the impact on communities in Colombia*
- John Collins (Co-ordinator, LSE IDEAS International Drug Policy Project): *Linking current developments in Irish drugs policy to the international policy context*
- Niall O'Connell (Service User Rights in Action): *Supporting a human rights approach to delivery of drug services*
- Anna Quigley (Co-ordinator, Citywide Drugs Crisis Campaign): *20 years' experience of community involvement – key lessons for the next National Drugs Strategy*

In the afternoon conference participants broke out into 12 workshops on the following topics:

- Medically-supervised injecting centres – a case study in bringing about drug policy reform in Ireland
- Understanding and responding to drug-related community violence and intimidation
- Implementing decriminalisation – developing a model that works in Ireland
- Developing the unique role of community drug projects – the factors that make them effective in their work and the challenges they are facing
- The role of the media in the discussion of social policy – how to support a rational and informed public debate on drug policy reform
- Developing a human rights approach to delivery of drug services – A case study on the experience of methadone treatment
- Women and the National Drugs Strategy – the impact on women of current drug policy and what needs to be included in the next NDS
- Equality and diversity in the new NDS – how to ensure inclusion of Travellers, New Communities, LGBT and other minority groups
- The value of family support – how the value of family support work can be understood and measured
- The role of youth work in developing and supporting effective models of drugs education, prevention and harm reduction
- Developing an integrated approach to the issues of drug use and homelessness – the experience from the frontline
- What Ireland can contribute to UNGASS 2016 – examining the concepts of regulation and legalisation

Videos of the speeches, and PowerPoint presentations made at workshops, are available on line at http://www.citywide.ie/citywide-20th-anniversary/presentations.html

(Compiled by Brigid Pike)

1 For more information on Agenda 2030, visit https://sustainabledevelopment.un.org/post2015/transformingourworld

First national youth strategy launched

On 8 October 2015 the Minister for Children and Youth Affairs, Dr James Reilly TD, launched the *National youth strategy 2015–2020.*[1] Ireland's first-ever youth strategy, it sets out the government's aim and objectives for young people aged 10 to 24 years, so that they can be active and healthy, achieve their full potential in learning and development, be safe and protected from harm, have economic security and opportunity, and be connected and contribute to their world. The strategy focuses particularly on young people experiencing, or at risk of experiencing, the poorest outcomes.

The National Youth Strategy identifies some 50 actions to be delivered by government departments, state agencies and others, including voluntary youth services, between 2015 and 2017. The actions include access to online youth mental health services, a national obesity policy and action plan, youth entrepreneurship initiatives in schools and youth work settings, and opportunities for young people furthest from the labour market.

In launching the National Youth Strategy, the Minister announced a new Youth Employability Initiative. This €600,000 initiative will provide grants to voluntary youth services for programmes that target disadvantaged young people to improve their employability. The initiative will target young people who are most at risk of unemployment and who are not in education, employment or training and will provide programmes for them to enhance their skills. It is anticipated that up to 20–25 new youth projects and an estimated 200–300 young people could be assisted by this initiative.

The wider context

The National Youth Strategy has been developed within the context of the *Better outcomes, brighter futures: the national policy framework for children & young people 2014–2020*, which is Ireland's first national policy framework for children and young people aged 0–24 years.[2] This policy framework captures all children and youth policy commitments across all government departments and agencies in relation to five outcome areas and six key transformational goals.[3]

As well as the National Youth Strategy described above, two other strategies are being rolled out within the context of this over-arching policy framework:

- The *National strategy on children and young people's participation in decision-making, 2015–2020*, was published in June 2015.[4] The action plan for 2015 published with this strategy includes the following commitments (p. 48):
  - 'Young people will be centrally involved in the development and management of drug and alcohol-free venues and programmes for young people (e.g. youth cafés, alcohol-free music and dance venues, and sports venues), with an emphasis on those most at risk.
  - The Health Service Executive (HSE) will develop mechanisms, including consultation and feedback mechanisms, for the participation of service users, families and carers in the decision-making processes of mental health services for young people at local and national levels.
  - Children and young people will be consulted by services seeking to respond to parental substance misuse or substance misuse in families as targeted by the 'Hidden Harm' initiative.
  - Children and young people will be included in consultations with communities to inform the development of Primary Care Services.
- The *National early-years strategy* has yet to be published.

(Brigid Pike)

1 Department of Children and Youth Affairs (2015) *National youth strategy 2015–2020.* Dublin: Government Publications. http://www.drugsandalcohol.ie/24606/

2 Department of Children and Youth Affairs (2014) *Better outcomes, brighter futures: the national policy framework for children & young people (2014–2020)* Dublin: Government Publications. http://www.drugsandalcohol.ie/21773/

3 For an overview of the outcomes and aims, see Keane M (2014) National policy framework for children and young people *Drugnet Ireland* (51): 5–6. http://www.drugsandalcohol.ie/22906/

4 Department of Children and Youth Affairs (2015) *National strategy on children and young people's participation in decision-making, 2015–2020* Dublin: Government Publications. http://www.drugsandalcohol.ie/24612/

Health behaviour in school-aged children, 2014

The first Health Behaviour in School-Aged Children (HBSC) survey was conducted in Ireland in 1998 and has been repeated every four years since. In 2014 Ireland participated for the fifth time in the HBSC study. The survey included 13,611 school-children drawn from 3rd class in primary school through to 5th year in post-primary school; 230 primary and post-primary schools across Ireland participated. Data were collected on general health, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries, bullying and sexual health behaviours. The main results were published in December 2015.[1]

This article describes the results pertaining to the use of alcohol and other substances, which were reported in the main report, and makes comparisons with the previous HBSC surveys. It also includes a more in-depth analysis of alcohol and cannabis use, which was prepared by the HBSC at the Health Research Board's request.[2]

Health behaviour in school-aged children, 2014 *(continued)*

Alcohol

Overall, 51 per cent of 13–17-year-olds reported that they had ever had an alcoholic drink. Use of alcohol increased with each year of age and, with the exception of 17-year-olds, boys were more likely than girls to have ever drunk an alcoholic drink (Figure 1).

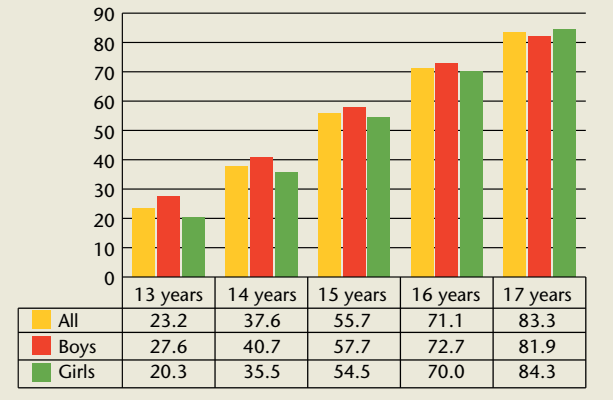


Figure 1: Percentage of 13–17-year-olds reporting having ever had an alcoholic drink, by age and gender, 2014

Almost one in five 13–17-year-olds (19.3%) reported that they had drunk alcohol in the last 30 days. A higher proportion of boys in all age groups (except for 17-year-olds) reported drinking in the last 30 days, compared to girls (Table 1).

Table 1: Percentage of 13–17-year-olds reporting having had an alcoholic drink in the past month, by age and gender, 2014

Age	All	Boys	Girls
13 years	4.9	6.1	4.2
14 years	12.9	13.6	12.4
15 years	24.1	25.5	23.2
16 years	42.7	43.4	42.2
17 years	61.1	57.7	63.7

Over one-quarter of 13–17-year-olds (26.6%) reported that they had ever been 'really drunk'. For each age, boys were more likely than girls to report lifetime drunkenness (Figure 2).

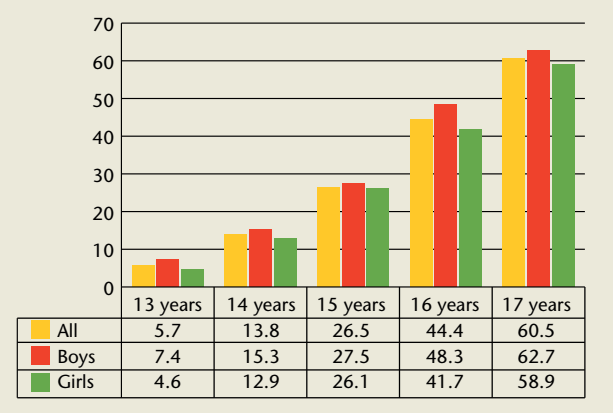


Figure 2: Percentage of 13–17-year-olds reporting having ever been 'really drunk', by age and gender, 2014

Cannabis

The majority of 13–17-year-olds (90.1%) reported that they had never used cannabis. Just under 10 per cent reported having used cannabis in the last 12 months. Cannabis use increased with each year of age and was more common among boys (Figure 3). There were no statistically significant social class differences.

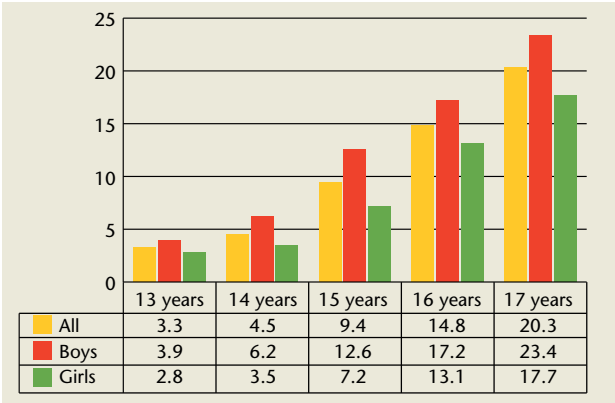


Figure 3: Percentage of 13–17-year-olds reporting cannabis use in the past year, by age and gender, 2014

Overall, in 2014 one in twenty (5%) school-aged children reported using cannabis in the last 30 days (Table 2).

Table 2 Percentage of 13–17-year-olds reporting use of cannabis in the last 30 days, by age and gender, 2014

Age	All	Boys	Girls
13 years	0.9	1.1	0.7
14 years	2.6	3.0	2.4
15 years	6.7	8.8	5.2
16 years	9.0	11.3	7.3
17 years	11.0	13.8	8.8

Trends in alcohol and cannabis use among Irish school-aged children, 1998–2014

The percentage of school-aged children reporting having ever had an alcoholic drink has decreased steadily since 1998, especially among 13–15-year-olds (Figure 4). In 1998, 65.6 per cent of 13–year-olds and 72 per cent of 14–year-olds had ever consumed alcohol, compared to 23.2 per cent and 37.6 per cent respectively in 2014. However, the incidence of alcohol use among 17-year-olds remained consistent throughout the five time periods.

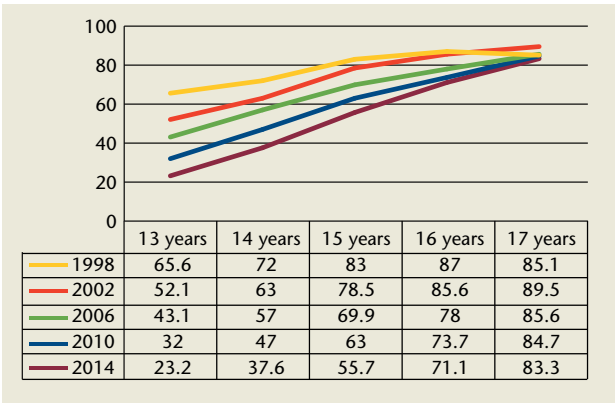


Figure 4: Trends in lifetime use of alcohol among school-aged children, 1998–2014

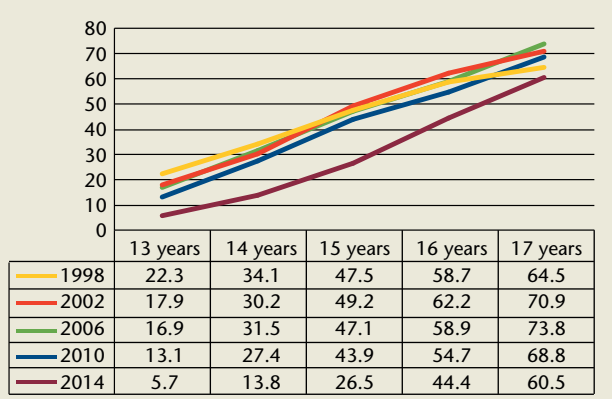
Health behaviour in school-aged children, 2014 *(continued)*

Levels of lifetime drunkenness have also decreased and this is most apparent among 13–15-year-olds. There is less variation among 17-year-olds (Figure 5) Similar to alcohol, there has been a steady decrease in the lifetime use of cannabis among 13–17-year-olds. This decrease can be observed across all ages (Figure 6).

Overall, there was a decrease in self-reported alcohol and cannabis use among school-aged children in Ireland in 2014 when compared to 2010 and earlier surveys. This may represent a true decrease, possibly owing to children having less pocket money in recent years because of the recession, or it may be the result of sampling variation, or a combination of both factors.

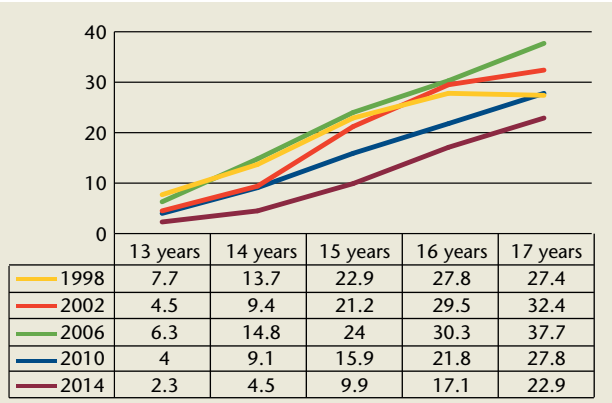
These decreases are welcome, especially among younger teenagers, as the immaturity of their brains makes them particularly vulnerable to the harmful effects of alcohol. Delaying initiation of drinking also decreases the likelihood of developing alcohol dependence in later life. However, it is important to note that substance use is still common among Irish school-aged children, with one in five 17-year-olds using cannabis in the previous year and 60.5 per cent having ever been drunk. Efforts to reduce Irish school-aged children's substance use need to continue.

(Deirdre Mongan)



	13 years	14 years	15 years	16 years	17 years
1998	22.3	34.1	47.5	58.7	64.5
2002	17.9	30.2	49.2	62.2	70.9
2006	16.9	31.5	47.1	58.9	73.8
2010	13.1	27.4	43.9	54.7	68.8
2014	5.7	13.8	26.5	44.4	60.5

Figure 5: Trends in lifetime drunkenness among school-aged children, 1998–2014



	13 years	14 years	15 years	16 years	17 years
1998	7.7	13.7	22.9	27.8	27.4
2002	4.5	9.4	21.2	29.5	32.4
2006	6.3	14.8	24	30.3	37.7
2010	4	9.1	15.9	21.8	27.8
2014	2.3	4.5	9.9	17.1	22.9

Figure 6: Trends in lifetime use of cannabis among school-aged children, 1998–2014

1 Gavin A, Keane E, Callaghan M, et al. (2015) *The Irish Health Behaviour in School-aged Children (HBSC) study 2014* Dublin: Department of Health and National University of Ireland, Galway. www.drugsandalcohol.ie/24909/

2 Perry C, Keane E and Nic Gabhainn S (2015) *Short report HBSC Ireland 2014. Alcohol and cannabis use in school-children in Ireland.* Galway: Health Promotion Research Centre, National University of Ireland, Galway.

Women and addiction

On 13 November 2015 the Dublin Business School (DBS) held a day-long conference on women and addiction.[1] The conference sought to explore the challenges faced by women in addiction by promoting dialogue about the issues experienced by these women in contemporary Ireland, and about the challenges faced by those working in the field. The conference brought together practitioners, students, volunteers, and individuals and groups with an interest in women and addiction.

The conference was divided into two themes, which ran concurrently: women in addiction, and women in recovery. During the morning a number of speakers shared their knowledge, expertise and practice of working with women in addiction in Ireland. At the end of the morning session, RADE (Recovery through Art, Drama, Education) participants performed their own drama, *Get stoned*, which challenges stereotypical perceptions of drug users, law enforcement, the community and politicians with regard to drug use. The afternoon session was comprised of a series of workshops,followed by a showcase of available services by a number of treatment service providers.

This article provides a brief overview of the 'Women in Recovery' theme. The opening address on the 'women in recovery' theme was given by the Dean of the DBS, who welcomed delegates, provided an overview of the college and applauded the students on the MA in Addiction Studies for organising the conference.

Gary Broderick, director of the Saol Project, spoke about trauma-informed care for women. Saol is the first woman-specific, feminist drug rehabilitation project in Ireland and is located in Dublin's north inner city. It is for women who are seeking to recover from drug use and promotes the needs of female drug users and their children. Mr Broderick discussed how the needs of women who use drugs differ from those of men.

Many women who abuse drugs do so as a result of a specific traumatic event, such as physical or sexual abuse. Therefore 'trauma-informed care' is required to ensure interactions with women are informed by the impact of the trauma that they have experienced. Gary spoke about Lisa Najavitis' manual *Seeking safety,*[2] in which she suggests that 99 per cent of women attending addiction services have experienced trauma and that 50 per cent will be found to have post-traumatic stress disorder (PTSD). Gary highlighted that recovery for women is more complex, quite often because of the role they play in their families.

Women and addiction *(continued)*

Drawing on findings from research, Dr Marguerite Woods focused on the image of women as users of drugs and as mothers, their experiences of stigma, their interactions with services, and the impacts of women's drug use on their parenting role and relationships with others. The difficulties faced by women who use drugs include the stigma which is attached to being a mother who uses drugs, fears about the impact their drug use might have on their children and fears of losing their children because of their drug use. Dr Woods said that women who use drugs are often portrayed as villains rather than victims, and are viewed as victimisers of others, especially their children. Regarding the implications for policy and practice, Dr Woods highlighted the importance of addressing a woman's needs rather than, or as well as, the needs arising from their drug use for their children and others. Gender-specific issues require exploration as do the issues of domestic abuse and a life after drug use for women.

Mary O'Connor, governor of the Dochas Centre in Mountjoy Prison, Dublin, spoke of the needs of women in prison. She described the process that occurs when a women is taken into custody at the Dochas Centre. She said some women see prison as a means to accessing drug treatment, a safe haven where they can access services such as a GP, dentist or other specialist clinic. Ms O'Connor said the neediest of those in custody are more likely to be homeless, addicted to legal or illegal substances, and their imprisonment usually relates to their being a nuisance as well as a danger to themselves rather than their being a danger to society.

(Ita Condron)

1 Further information on the Dublin Business School is available at http://www.dbs.ie/

2 Najavitis L M (2002) *Seeking safety: a treatment manual for PTSD and substance abuse.* Guilford, New York. http://www.drugsandalcohol.ie/3597/

Grandparents caring full-time for grandchildren owing to parental drug use

No research had been done in Ireland on the issue of grandparents caring full-time for their grandchildren in situations where parents are substance abusers before the study described here was undertaken.[1] Intending their research to be an initial contribution, the authors of this study sought to examine:

- How do grandparents assume the caring role for their grandchildren?
- What do grandparents identify as the positive aspects of occupying this role, as well as its associated stresses and strains?
- How satisfied or dissatisfied are grandparent carers with the support they receive from the child protection service and, to a lesser extent, from addiction treatment services?

Participants were recruited through the National Family Support Network (NFSN), the national co-ordination body for a network of locally-based family support groups. To be included in the study the grandparents had to have been providing full-time care to grandchildren for at least six months, and to have taken on the caring role because of the parent's drug use. Eleven participants (nine individuals, one couple) came forward, and 10 semi-structured interviews were conducted using a qualitative approach. After 10 interviews the authors decided that saturation point had been reached and any additional participants were unlikely to reveal new information. As the first author was an employee of NFSN, a number of robust measures were implemented to reduce bias, including involving a researcher who was not an NFSN employee.

The main themes and sub-themes that emerged from the interviews were:

- the decision to care
- the challenges of being grandparent carers
  - health and behavioural needs of grandchildren
  - financial difficulties
  - relationships with the family
  - physical and mental health problems
- support from social and health services
  - the child protection system
  - addiction services
  - financial payments from statutory bodies.

This article will focus on two themes – the decision to care, and the grandparents' experiences of interacting with addiction services.

Decision to care

Most grandparents became carers because of a sense of responsibility, to keep their grandchildren out of non-relative foster care, or to ensure that the children received an adequate level of care that they were not receiving from their own parents.

> *The HSE…gave me a phone call one morning from* [sic] *work, and when I came home they had the two children in my sitting room with a carrier bag; and it was take them for three months or they were going into care…. it was a shock.*

Addiction services

Participants in the study had mixed views on the addiction services they had encountered during their time as carers. Centralised treatment facilities and residential centres were viewed much more negatively than local addiction services.

Some participants held the view that addiction services were unwelcoming to relatives, and that the services were reluctant to challenge their children regarding their negligence as parents. Some of the participants had funded several residential treatment stays for their child:

Grandparents as carers *(continued)*

We paid for private rehab … you name it she has been in it. It must been 14 rehabs. One of them, we re-mortgaged our house for €10,000 and sent her to Liverpool. She walked out after a week.

On a more positive note, family support services, which were normally located in community-based addiction services, were accessed by eight of the participants and were highly valued by those who accessed them. Grandparents learned about concepts of addiction for the first time, although this was often in an unstructured manner. 'Enabling' was the concept most mentioned by participants. Having learned about it, many grandparents began to refuse requests from their child for monetary or other forms of assistance. The authors noted that grandparents did not perceive the introduction of the concept of enabling as placing primary blame on them for their children's drug use.

A related theme to emerge from the study was the relationship between child protection services and addiction services. The authors noted in the introduction to the report that in Ireland there is an absence of integrated responses to addiction and child protection issues. This issue was highlighted by the participants, with specific complaints about the lack of expertise among child protection social workers in relation to addiction.

Conclusions

The authors concluded that the participants faced several hardships in their role as carers. These included mental health difficulties, refusal of support from statutory bodies, and difficulty accessing statutory payments and the associated financial difficulties. The authors suggested that many of these difficulties could be addressed without any further research. More cooperation between child protection and addiction services, including the capacity of non-specialist social service and health professionals to deal with addiction issues, could help alleviate the difficulties faced by grandparents.

(Martin Grehan)

1 O'Leary M and Butler S (2015) Caring for grandchildren in kinship care: what difficulties face Irish grandparents with drug-dependent children? *Journal of Social Work Practice in the Addictions* (15): 352–372. http://www.drugsandalcohol.ie/24949/

Methadone-maintained patients in primary care

The use of primary health services by methadone-maintained patients (MMPs) is an under-researched area internationally. The aim of the study described here, conducted by researchers in Trinity College Dublin (TCD), was to examine this issue in the Irish context using a matched case-control study.[1] The researchers particularly looked at chronic disease and multi-morbidity among MMPs.

TCD maintains a research network of GP practices throughout the greater Dublin area. Thirteen practices in this network have electronic patient records and provide methadone maintenance treatment (MMT). All 13 agreed to participate.

An MMP had to have attended the practice for both MMT and primary health care for at least one year to be included in the study. In total, 207 MMPs met the criteria, and were matched with 207 controls according to sex, age, practice (to account for geographical variability), and eligibility for the General Medical Services (GMS) scheme. The authors considered the combined sample size of 414 one of the major strengths of the study.

Information collected about participants from electronic records included demographic details, chronic disease data, repeat medications, and information relating to smoking, alcohol use, and non-opiate drug use. A number of variables related to health service utilisation were also recorded, such as number of GP and nurse consultations, referrals to hospital, and use of the out-of-hours GP service. Data were extracted from the electronic system using an in-depth form, which included reading all consultation notes. The authors reported some issues with data collection that may have resulted in the under-estimation of some of the variables, especially MMP outpatient attendances. In addition, specialist medicines were excluded from the analysis owing to a lack of systematic documentation in the 13 practices. Statistical tests conducted included independent samples t-tests, Pearson chi-squared tests, risk estimation, odds ratios (OR), 95% confidence intervals (CI) and binary logistic regression.

There were no statistically significant differences in demographics between the MMP group and the control group: 43% of the sample was female, 57% male; 16% were private patients, 84% GMS patients.

Chronic disease and multi-morbidity

By comparing means using t-tests and OR, the authors presented evidence for the increased likelihood of chronic illness among MMPs versus controls. Compared to controls, MMPs were statistically significantly more likely to have:

- chronic disease (OR 9.1 [CI 5.4 – 15.1])
- multi-morbidity, i.e. two or more chronic diseases (OR 6.6 [CI 4.3 – 10.2])
- repeat medications (OR 5.8 [CI 3.7 – 8.9])
- history of smoking (OR 4.8 [CI 3.2 – 7.2])
- excess use of alcohol (OR 2.9 [CI 1.6 – 5.2])
- non-opiate problem drug use (OR 141.2 [CI 63.3 – 315.3])
- psychiatric disease (OR 6.1 [CI 3.9 – 9.3])
- respiratory disease (OR 3.3 [CI 1.9 – 5.9])
- infectious disease (OR 118.5 [CI 28.8 – 489.9])

It is of note that while MMPs were significantly more likely to have a chronic disease (OR 9.1 [CI 5.4 – 15.1], (95% CI), compared to controls, if HIV, and hepatitis B and/or C were excluded, then the OR was less emphatic, dropping to 4.2 (CI 2.7–6.4). As expected, the OR for problem use of non-opiate drugs was highly significant, 141.2 (CI 63.3–315.3).

Methadone-maintained patients *(continued)*

MMPs have a lower average incidence of cardiovascular disease (0.06 vs 0.14, p=0.04), although the OR for this same category is not significant. This seems to indicate that MMPs may have lower levels of cardiovascular disease than controls, which seems counter-intuitive given the reported differences in the incidence of chronic diseases, and the history of smoking and respiratory disease. While the authors did not explicitly comment, they did observe that often medical problems among MMPs emerge as 'unanticipated "door-handle symptoms" during time-pressured, protocol-driven methadone appointments' .

The authors constructed several binary logistic regression models. Of most interest was the model for chronic disease occurrences, age, sex, GMS status, current dose of methadone, and smoking. The model was restricted to MMPs only and the strongest predictor of chronic disease was being a GMS patient with an OR of 7.2 (CI 2.4–22.0). The authors concluded that the data suggested that GMS patients were sicker than non-GMS patients. A link to deprivation was also suggested, though the authors noted that non-GMS MMPs may have been part of a sub-group of MMPs who had shown increases in health and income owing to MMT.

Health service utilisation

MMPs used their primary care facility on average 32 times a year and, of these, 30 were for MMT. Controls on the other hand had an average of only three visits a year. Visits were broken into three non-mutually exclusive categories to allow comparisons – 'medical', 'nursing' and 'methadone'. MMPs were more likely to have attended for medical or nursing assessments. The majority (87%) of medical assessments and 20 per cent of nursing assessments took place during an MMT consultation.

The study concluded that MMPs cost the health service as a whole more than the baseline cost of MMT:

> *MMPs had higher levels of health service utilisation at a practice and secondary care level. They generated a higher workload for GPs and increased administrative tasks for primary care services. They spent more time in emergency departments, inpatient beds, and outpatient clinics.*

Conclusions

The authors concluded that health care policy must reflect the fact that MMPs are attending GP practices more often than non-MMPs, the strain this places on those services, and the risks associated with a singular focus on drug-related issues. The main recommendations of the authors included a more holistic approach to integrating MMT with general medical needs, and the promotion of better record-keeping with regard to chronic diseases. The authors identified an opportunity to increase the role of the GP practice nurse as the study suggested this resource was under-used in MMT.

They also suggested that GPs should be offered incentives to be trained in MMT and any formal review of MMT GP remuneration should take into account the additional workload of taking care of MMT patients.

(Martin Grehan)

1 O'Toole J, Hambly R, Cox AM, O'Shea B and Darker C (2014) Methadone-maintained patients in primary care have higher rates of chronic disease and multimorbidity, and use health services more intensively than matched controls. *The European Journal of General Practice* (20): 275–20. http://www.drugsandalcohol.ie/24352/

Overdose risk among heroin users: a pilot prevention study

The main cause of death among injecting drug users (IDUs) is opiate-related overdose. Some of the most common risk factors for overdose are age, gender, injecting drug use, drug purity, low tolerance, polydrug use, and recent imprisonment/release from prison. Problem drug users with a history of self-harm are also at increased risk of overdose.

A study in two Cork addiction services aimed to investigate injecting drug users' experience of fatal, non-fatal, accidental and intentional overdose and to ascertain the requirement for any overdose prevention training and resuscitation skills.[1]

There were three phases to the study, which was part of an internal audit of service users.

- Phase one explored the experience of overdose among 52 service users attending the centres in 2012, measured their understanding of appropriate responses to overdose and assessed any need for resuscitation training. Questions were asked about the service users' lifetime and recent (last six months) experience of non-fatal, accidental or intentional overdose, and the drugs involved.
- Phase two consisted of playing a DVD training programme on overdose prevention in the waiting room of the two centres for four weeks. After this, 26 services users out of the original 52 interviewed were re-interviewed about their overdose awareness and resuscitation skills.
- Phase three was a pilot training project of practical resuscitation skills and overdose prevention aimed at both service users and staff, which took place in 2013. In all, 14 service users, 10 family members and two staff took part in this phase.

Results of phase one were as follows:

- 60% had ever overdosed.
- 10% had overdosed in the previous six months.
- 80% of overdoses were accidental.
- Heroin was involved in 60% of all overdoses.
- Benzodiazepines were involved in 47% of all overdoses.
  - Benzodiazepines were more commonly reported in intentional overdoses (83%).
- 56% had witnessed a non-fatal overdose.
  - 52% of non-fatal overdoses occurred in a private dwelling.

Overdose prevention *(continued)*

- 19% had witnessed a fatal overdose.
  - 87% of fatal overdoses witnessed occurred in a private dwelling.
- Of those who had witnessed an overdose,
  - 80% called an ambulance, and
  - 55% reported putting the person into the recovery position.
- 54% reported never or rarely worrying about overdose.
- 92% knew what number to call for an ambulance.
- 62% reported they knew what the recovery position was.
- 65% reported an interest in learning basic resuscitation skills.

Results of phase two showed that after the intervention, 100% of participants knew what number to call for an ambulance, and 73% knew what the recovery position was.

For phase three, a brief evaluation and a focus group were conducted. The outputs highlighted a number of issues to be considered when considering how to prevent overdose risk behaviours – release from prison; polydrug use; the psychological effects of the experience of overdose for service users, for example the death of friends; the need for overdose prevention training for service users in order to equip them with the skills to prevent fatal overdoses; and the need for training and development for professionals working at the points of contact, for example in emergency departments.

While the sample size was small, and the study relied on self-reported answers, the participant responses were similar to those in other studies on overdose prevention. The authors felt that studies like theirs play an important part in understanding the dynamics of overdose in Ireland and highlight the need for overdose prevention training. They recommended the provision of intranasal naloxone to service users attending needle exchange and the consideration of supervised injecting rooms.[2] The authors concluded that providing overdose prevention training and basic resuscitation skills can have a positive outcome not only for the individual but also for their peers and the wider community.

(Suzi Lyons)

1 Horan J, Deasy C, Henry K, O'Brien D and Van Hout MC (2015) Overdose risk perceptions and experience of overdose among heroin users in Cork, Ireland. Preliminary results from a pilot overdose prevention study. *Heroin Addiction and Related Clinical Problems* (17): 19–26. http://www.drugsandalcohol.ie/24795/

2 On 15 December 2015 the Irish government approved additional heads for inclusion in the Misuse of Drugs(Amendment) Bill 2015 to allow for supervised injecting facilities in Ireland. http://health.gov.ie/blog/press-release/o-riordain-welcomes-government-approval-for-medically-supervised-injection-facilities/

Community Alcohol Response and Engagement

On 27 October 2015 Aodhán Ó Ríordáin TD, Minister of State for Equality, New Communities and the Drugs Strategy, launched the evaluation report on the Community Alcohol Response and Engagement (CARE) alcohol treatment project.[1] The CARE project was a cross-task force initiative funded by the HSE. Its aim was to provide cross-disciplinary support across three task force areas – Ballymun, Finglas and North County Dublin – to clients seeking to address problematic alcohol use. The project was rolled out between September 2014 and June 2015.

The CARE programme involved out-patient medical and psycho-social treatments tailored to the needs of individual clients. The treatment pathway followed a five-step process:

- referral,
- initial assessment and AUDIT,
- comprehensive assessment,
- care planning, care giving and referral, and
- aftercare and exit planning.

Clients were given an initial assessment using the NDRIC-endorsed AUDIT system.[2] Those who scored 14 or below were given brief advice and guidance while those scoring 15 or higher were put forward for a comprehensive assessment. The comprehensive assessment gauged the clients' needs in relation to a number of factors including their history of drug and alcohol use, medication, social circumstances, risk-screening and goals. Once the comprehensive assessment was completed, a member of the care team was assigned to develop a care plan in line with the client's needs and goals. Finally, aftercare was provided to those clients who required continued psycho-social support along with exit planning to cease engagement with the CARE team.

The effectiveness of the pilot programme was evaluated using several different methods. The researchers reviewed clients' case files (n=105), undertook client interviews (n=6) and conducted a client audit (n=40). With regard to professionals and policy makers, the researchers conducted interviews (n=13) and surveys (n=38). The final document incorporated feedback from these stakeholders.

In total, 142 clients were referred to CARE, and of these, 105 (74%) attended for the initial assessment. GPs accounted for 40 per cent (42) of referrals who attended for the initial assessment, while psycho-social partners accounted for 34 per cent (36); in all three sites, the lowest number of referrals who progressed on to an initial assessment came from among the clients themselves. Of the 105 people who attended their first appointment, 104 people (99%) completed the initial assessment (one person was referred to A&E and received no further care).

The gender breakdown of those who attended for an initial assessment (n=105) was almost even, with 52 per cent male and 48 per cent female. The median age was 45 years. Over half (56%) were unemployed. A significantly higher proportion of people were employed in the North County Dublin cohort (56%) than in Finglas (34%) or Ballymun (19%).

Community Alcohol Response *(continued)*

AUDIT scores were taken for 100 of the clients who attended for initial assessment, and 86 per cent were deemed to be alcohol dependent. Of the 89 clients attending for initial assessment who consented to urinalysis, 49 per cent tested positive for drugs other than alcohol. Of these, benzodiazepine was by far the most common drug, present in 37 per cent of clients, followed by cannabis (11%).

Table 1 illustrates the services that the clients who attended for the initial assessment availed of across the whole programme. Of the 105 clients for whom an initial assessment was offered, 92 (88%) also received psycho-social supports from a partner site, with the exception of 13 (13%) who declined this support or already had an alternative source for this support. Eighty-two of those who attended for an initial assessment (78%) went on to complete the comprehensive assessment.

Table 1: CARE service provision to clients across the whole programme (n=105)

Service Type	Number (%)
Comprehensive assessment	82 (78)
Mental health assessment	67 (64)
Physical health assessment	96 (91)
Blood testing	66 (63)
Urinalysis	89 (85)
Mental health referral	23 (22)
Physical health referral	32 (31)
Referral to residential alcohol services	12 (11)
CARE detoxification *Completed CARE Detox* *Disengaged CARE Detox* *Pharmacological Treatment (percentage of 105)*	23 (22) *18* *5* *22 (21)*
Detoxification support for non-care detox	20 (19)
Alcohol awareness group	17 (13 clients; 4 family members)
Sober Skills Group	9 (6 CARE; 3 non CARE)

Source: Dermody and Banka 2015: pp. 41 & 43

The case audit of the 40 client files found that all clients had a care plan, and 80 per cent had multiple goals. The main goals are summarised below.

- 39 clients (98%) had alcohol reduction as a goal, of whom 36 (92%) had made progress towards the goal and 32 (82%) had made significant progress in reducing alcohol intake, with over half of these clients becoming abstinent and over half maintaining abstinence.
- 18 clients (45%) identified pro-social engagement (being able to participate in social activities without focusing on alcohol consumption) as a goal. Half of these clients reported progress in this area.
- 16 clients (40%) had improving relationships with family as a goal, of whom 11 (69%) reported progress, with 10 of these showing minor improvement and one showing significant improvement.

The report found that the opinions of the professionals involved, e.g. psycho-social workers and GPs, were universally positive towards CARE. Improvements in knowledge, skills, care planning and more effective referrals were all cited as positives from the programme. Value for money was also cited as a positive of the programme as it used services and resources already available.[3]

The project had a number of limitations. Only 40 client cases were explored in depth, with an even lower number of in-depth interviews with professionals and policy makers. It is difficult to assess the success of a project based on such a small sample. Recall bias on the part of staff performing the case file analysis was not controlled for, as the analysis was not based on pre- and post-programme data collection but was drawn from the staff's own subjective perspective, either from memory or from written case notes/files. As there was an absence of pre- and post-programme data, it was also difficult to gauge the impact of the project on the clients. Family members were mostly reluctant to engage with the project, which meant analysis of the project's impact on family members was not possible. Lastly, although the project ran for a year in the three task force areas, the service had only been rolled out in one of the pilot sites for 5–6 months by the time the evaluation was undertaken. Thus, there was insufficient data from this site to provide the same level of detail regarding its effectiveness compared to the other sites.

The authors also highlighted challenges in the project to do with time and resources. There were bottlenecks in the delivery of some support services, which led to clients having to go on waiting lists, and a lack of resources was deemed to have impacted on the delivery of the programme. Some participants highlighted a lack of clarity regarding certain parts of the programme despite protocols and governance frameworks being in place. Lastly, data collection was seen as an issue which would need to be addressed.

Following the evaluation, the authors made a series of recommendations including the following:

1. increase clinical nursing hours and psycho-social support;
2. develop a training manual to strengthen the clarity of protocols, particularly policy and procedures in relation to key working and client-related communication;
3. add pre- and post-participation measurement scales in order to allow more effective measurement of client progress, ideally through use of an information system; and
4. measure the economic and wider social impacts of the CARE programme.

The CARE programme pilot was deemed a success and a highly valued addition to community alcohol treatment. The authors stated that the programme was consistent with local and national strategic goals in relation to alcohol treatment in the community, and felt that it could easily be replicated in other areas.

(Derek O'Neill)

1 Dermody A and Banka P (2015) *Evaluation of CARE (Community alcohol response and engagement) pilot project* Dublin: Ballymun Local Drugs & Alcohol Task Force and Quality Matters. http://www.drugsandalcohol.ie/24700/

2 AUDIT is a test designed to determine if a person is at risk of alcohol abuse problems. The higher the overall AUDIT score, the more problematic a person's drinking is thought to be. In general, AUDIT scores between 8 and 15 indicate a medium level of alcohol problems, with 16 and above seen as indicating alcohol dependence and warranting further evaluation and treatment. NDRIC is the National Drug Rehabilitation Implementation Committee.

3 The total cost of the project was €116,000, of which €97,725 was staff costs (1 full-time co-ordinator and 1 FTE clinical nurse specialist).

Drug and Alcohol Awareness Week in the Midlands

The Midland Regional Drugs and Alcohol Task Force (MRDATF) ran its annual Drug and Alcohol Awareness Week from 9 to 14 November 2015. A total of 29 events were organised across counties Longford, Westmeath, Laois and Offaly.[1]

The awareness week was launched by Susan Scally, Principal Officer, Drugs Policy Unit, Department of Health, who stated at the launch in Athlone:

> *I am delighted to be here today to launch the Drug and Alcohol Awareness Week and would like to congratulate the Task Force and all the partner agencies for running this annual campaign. I especially welcome the focus on educating young people about the consequences of drug and alcohol misuse and the range of events which are designed to encourage young people to discuss the issues involved in an open and frank way.*

The primary role of the MRDATF, which is funded by the Department of Health, is to research, develop, implement and monitor a co-ordinated response to the problem of drug and alcohol misuse as experienced in the four midland counties. The aim of the awareness week is to increase awareness of drug- and alcohol-related issues and to highlight the drug and alcohol support services available.

The 29 events were organised by the MRDATF and community, voluntary and statutory agencies across the midland region. Each event had a specific target audience – service providers, the general public, parents, students and under-18s. The County Longford Drug and Alcohol Forum hosted a 'Strength in local knowledge' seminar at which their new service information poster was launched. Several sessions were held on 'suicide alertness', targeting everyone, and also a 'responding to intimidation' seminar.

Dr Susan Redmond, a leadership coach and consultant based in County Galway, held meetings in several locations on 'Connecting with your teenager – mindfulness for parents during adolescent development'. In addition, there were cultural, musical and art events.

Cannabis conference

On the morning of the launch Susan Scally also opened a cannabis conference, *The facts about cannabis.* Organised by the MRDATF and HSE CADS (Community Alcohol and Drug Service), the aim of the conference was to bring together interested individuals and agencies working in the field of addiction to engage in meaningful learning and discussion regarding the impact of cannabis use on the individual and society.

Attending the MRDATF's annual Drug and Alcohol Awareness Week were (L-R) – Dr Suzi Lyons, Senior Researcher HRB, Dr Adam Winstock, Founder Global Drug Survey, Consultant Psychiatrist & Addiction Medicine Specialist, Antoinette Kinsella, Co-ordinator MRDTF, Peter McEvoy, Chairperson MRDATF, Susan Scally, Principal Officer, Drugs Policy Unit, Department of Health, Philip James, Clinical Nurse Specialist, HSE YoDA, Fran Byrne, Regional Manager HSE CADS

Guest speakers at the conference included:

- Dr Suzi Lyons, senior researcher, National Health Information Systems (NHIS) in the Health Research Board
- Dr Adam R Winstock, founder of the Global Drug Survey, and consultant psychiatrist and addiction medical specialist at the South London and Maudsley NHS Trust
- Philip James, clinical nurse specialist, HSE YoDA (Youth, Drug & Alcohol) Service

Dr Winstock said at the conference:

> *The cannabis story is changing. From new preparations and methods of use to synthetic cannabinoids and regulated markets cannabis has never been so interesting. There's so much that can be done to better educate users and health care providers to help people use more safely and help those who need treatment get the right help. I hope I can support all in attendance at the Cannabis Conference today to do that.*

(Suzi Lyons and Antoinette Kinsella)

1 For more information on the MRDATF visit http://www.mrdatf.ie/index.php

Culture and organisation in the Irish Prison Service

Culture and organisation in the Irish prison service: a road map for the future, a new report completed by the Inspector of Prisons, Judge Michael Reilly, and Professor Andrew Coyle, Emeritus Professor of Prison Studies at the University of London, examines all aspects of the administration and governance of the Irish prison system and identifies a number of deficiencies in administration, treatment of prisoners and delivery of services by prison staff.[1] The authors are particularly critical of inadequate and misleading reporting, a direct result of the absence of functioning line management structures in many prisons and a factor contributing to consistent breaches of agreed procedures.

The review examines several aspects of the work of the 3,380 staff in the Irish Prison Service (IPS), most of whom are prison officers, and recommends significant changes to management structures, career progression and staff reporting. It recommends substantial changes to the prison system's governance structures, in particular with regard to the manner in which the IPS reports to the government, the appointment of IPS board members and regional management structures.

Healthcare services

Recommended reforms include appointing a Director of Prison Healthcare Services, the person appointed to be a registered medical practitioner. The report notes that many prisoners have a poor health profile and providing adequate medical and nursing care in prisons presents significant challenges. The work of healthcare staff within the prisons system will be key to progress in this area: while there has been a steady increase in specialist civilian staff replacing prison officers in recent years, Irish prisons have been much slower than those in the United Kingdom. Nursing managers in the larger prisons lead teams of qualified nurses and there are 111 nurses currently working in the prison service, with 27 nursing places unfilled.

In contrast to countries like Norway and Scotland, which adhere to international standards relating to the provision of healthcare services in prisons, medical services in Irish prisons are not integrated with the general health administration in the community, and prison health policy is not necessarily compatible with national health policy. The authors cite a 2009 Health Service Executive (HSE) report, which recognised that the HSE was peripheral to prison healthcare delivery.[2] Recommendations on providing a clear definition of the role of prison nurses have not been implemented and staffing shortages and changes in conditions of employment have contributed to the frustration of nurses, unable to provide the level of nursing care they would wish.

Relationships between management and staff

The report observes that progress from a command structure to a management structure in the prison service lagged far behind that in other areas of public administration. Promotions have traditionally been through the ranks and there has been a blurring of the distinction between staff and management. Many officers spoke of an inflexible culture with an emphasis on ensuring things didn't go wrong, not on introducing new thinking. Promotion to a higher grade generally operates on a generic basis. This means that it has been possible for someone who has spent all of their career to date in a specialism, with minimal direct contact with prisoners or little management of staff, to be promoted to assistant governor or to one of the grades of chief officer and then be appointed to a position that requires first-line management of both staff and prisoners. A number of recently appointed assistant chief officers reported that they felt unprepared for their new responsibilities and that they found it difficult to gain appropriate respect from some other officers and even from prisoners. The chapter on staff learning and development highlights the disparity between employment practices in the prison system and the wider public service. It appears that PMDS (Performance Management and Development System) forms are not filled and after their initial training staff learning and development is not monitored.

Prisoners

The focus of this review was on how the current culture of the Irish prison system contributes to or undermines the development of the prison service. Its terms of reference meant that the authors concentrated on organisational issues, the nature of prison work and the experiences and capacity of staff within the IPS. The prisoners themselves are the subject of just one chapter. It is clear that much progress has been made in recent years in improving the conditions in which prisoners live and in identifying and responding to areas of particular concern. The introduction of a new complaints procedure and thorough investigations of deaths are two recent advances in this regard.

Historically, the autonomy granted to individual Irish prisons has meant that, unlike other countries, where a prisoner's destination is determined largely by an initial classification, prisoners in Ireland are usually allocated to the prison of first committal. The lack of a thorough individual assessment of prisoners militates against attempts to establish internal good order and, in some prisons, contributes the development of gang culture. Gang structures in prisons often mirror external affiliations and can be built around the distribution of drugs, threatening stability in the prison. There does not appear to be a clear operational strategy for dealing with gangs and individual staff members are unable to cope with the violence and intimidation that is part of gang activity. Often it is the victim, not the perpetrator, of this activity who is transferred to another prison or what is called a 'protective regime'.

Several issues relating to management of prisoners and their rehabilitation were beyond the scope of this review. The authors recommend that a separate review should deal comprehensively with these and should include the following in its terms of reference:

Irish Prison Service *(continued)*

- health care including mental health,
- drug and other substance abuse,
- education and skills training,
- the role of specialist staff in the prison environment,
- a higher priority for pre-release planning, and
- the parole system and the use of remission of sentence in the rehabilitation of prisoners.

(Brian Galvin)

1 Office of the Inspector of Prisons (2015) *Culture and organisation in the Irish prison service: a road map for the future* Dublin: Office of the Inspector of Prisons. http://www.drugsandalcohol.ie/24803/

2 Health Service Executive Nursing & Midwifery Planning & Development Unit (2009) *Nursing in the Irish Prison Service: working together to meet the healthcare needs of prisoners* Dublin: Health Service Executive. http://www.drugsandalcohol.ie/12520/

MQI annual review 2014

The Merchants Quay Ireland (MQI) annual review for 2014 was launched on 11 September 2015 by Uachtarán na hÉireann, Michael D Higgins, on the occasion of his visit to MQI's Drugs and Homeless Services.[1]

MQI's 18th annual review notes the continuing growth of homelessness and drug use. During 2014 MQI announced a number of developments and extensions to its services, most notably the establishment of The Night Café, completion of its client management system and the introduction of a dedicated mental health nursing position. MQI also published *Examining the profile and perspectives of individuals attending harm reduction services who are users of performance and image enhancing drugs,*[2] which was launched in November 2014 by Susan Scally, Head of the Drug Policy Unit in the Department of Health.

MQI's New Communities Support Service provided one-to-one support to 350 service users mostly from East European countries. The largest number of new community clients were from Poland.

MQI's needle-exchange service recorded approximately 26,400 client visits in 2014. The report highlights the continuing high level of demand for homelessness services: 79,636 meals were provided by the day and evening services, and 5,329 health-care interventions were provided.

The year 2014 saw MQI continue to provide its national prison-based addiction counselling service to 13 prisons. MQI successfully tendered and was awarded the contract to provide this service until 2017. Demand for the service continues to be high: 11,225 individual counselling sessions were provided, and 4,273 group attendances were recorded. In Mountjoy Prison, MQI's counselling service co-ordinates an inter-agency programme in the medical unit; during the year, 52 prisoners availed of the service, with 43 completing the programme.

MQI, in association with the Midland Regional Drugs and Alcohol Task Force and the Health Service Executive (HSE), administers the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. In 2014:

- The family support service provided 212 group and 994 individual sessions, and 302 supportive phone calls.
- The harm reduction service worked with 255 clients, providing 2,454 interventions.
- On average, 217 needle exchanges were provided each month.
- Athlone Open Door Centre had 144 clients, recording 2,835 visits in total and providing 2,266 meals.
- The Midlands Rehabilitation and Aftercare service worked with 76 individuals, providing 422 one-to one-sessions and 99 group sessions.

In 2014 MQI developed two other programmes in the Midlands region:

- The Day Programme is a Department of Social Protection Community Employment (CE) scheme and it worked with 10 individuals during the year.
- The Resettlement Programme has established relationships with local property owners and MQI provides eight beds for individuals in recovery.

Table 1: Services offered by MQI, number of participants and outcomes, 2014

Service	Type of intervention	Number of participants	Outcomes
Needle-exchange and health-promotion services	■ Promotes safer injecting techniques ■ HIV and hepatitis prevention ■ Safe sex advice ■ Information on overdose ■ Early referral to drug treatment services	3,179 used needle-exchange services, of which, 527 were new clients. 1,786 safer injecting workshops were provided.	
Outreach	■ Street contact work ■ Collecting used injecting paraphernalia ■ Liaison with various groups and professionals ■ Hospital visits	Over 1,000 clients engaged with the outreach team.	

Merchants Quay Ireland *(continued)*

Table 1: Services offered by MQI, number of participants and outcomes, 2014 (continued)

Service	Type of intervention	Number of participants	Outcomes
Primary healthcare services	■ Nursing ■ Counselling ■ GP service ■ Psychiatric nursing	1,804 nursing interventions. 811 counselling sessions. 1,985 GP consultations. 168 psychiatric nursing assessments	
Stabilisation services	Methadone substitution Gateway programme	20 Not available	
Aftercare	■ Drug-Free Day Programme ■ Weekly aftercare support group (post residential treatment in High Park and St Francis Farm)	19 clients admitted to the service 22 clients admitted to the service	55% completed the programme. 52% completed the programme.
Integration programmes	■ Ballymount House ■ Leixlip House with Respond Housing Association	17 admissions to aftercare housing.	Occupancy rate for Ballymount and Leixlip was 84%.
Training and work programmes	Community Employment (CE) scheme	144	Of the 42 who completed placements at MQI, 8 secured permanent employment, 3 returned to education and 3 moved to another course.
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	297 referrals (of whom 43 were admitted for detoxification)	8 clients received a Bronze An Gaisce Award.
St Francis Farm	Therapeutic facility offering a 14-week programme Detox facility	357 referrals (of whom 46 were admitted for rehabilitation) 289 referrals (of whom 64 were admitted for detoxification)	67% completed the programme. 69% completed their detox.

(Ita Condron and Vivion McGuire)

1 Merchants Quay Ireland (2015) *Annual review 2014.* Dublin: MQI. http://www.drugsandalcohol.ie/24503/

2 Merchants Quay Ireland (2014) *Examining the profile and perspectives of individuals attending harm reduction services who are users of performance and image enhancing drugs.* Dublin: MQI. http://www.drugsandalcohol.ie/23024/

Pavee Point celebrates 30 years

The celebration of 30 years of Pavee Point Traveller and Roma Centre was kicked off by the President of Ireland, Michael D Higgins, on 18 November 2015.[1] The President spoke about the work of the organisation and its pivotal role in the Traveller community, and how it had helped to make many positive changes over the past 30 years.

Gabi Muntean (community development worker) spoke about the decision to include Roma in the organisation and to change the name to the Pavee Point Traveller and Roma Centre. Other speakers included Martin Collins (co-director), Stasia Crickley (chairperson) and Missie Collins (primary health care worker). Music was provided by Mickey and Brid Dunne and also by Roma musicians.

(Suzi Lyons)

1 For further information see http://www.paveepoint.ie/president-helps-us-celebrate-30-years

Missie Collins, one of the speakers at the Pavee Point celebration, with President Michael D. Higgins and Mrs. Higgins at the event

Peter McVerry Trust annual report 2014

The Peter McVerry Trust (PMVT) annual report for 2014 was launched on 17 November 2015 by the Minister for the Environment, Community and Local Government, Alan Kelly TD.[1] During 2014 the Trust continued to tackle a wide range of needs – homelessness, drug misuse and social disadvantage – through the provision of services in areas such as homelessness prevention, housing, accommodation for homeless people, drug treatment and under-18s residential services.

During 2014 the Trust opened at least one new service in each of its four core areas of service provision. These new services, combined with the rapid rise in the number of people presenting as homeless, resulted in a large increase in participant numbers: during 2014 the Trust engaged with almost 4,460 participants across its services, representing an increase of 24 per cent since 2013.

Provision of drug treatment services is a crucial support for many participants. During 2014, 78 per cent of those accessing the Trust's services had current or past experience of drug misuse. The Trust's residential community detoxification service delivered support to 80 participants. These clients were admitted to the service seeking either detoxification from methadone or engagement with the residential cannabis cessation programme. This latter programme began in January 2013 as a direct response to the growing number of young people presenting with concerns about the impact of cannabis use on their lives.

PMVT continues to provide stabilisation and recovery services in both Dublin City and in North County Dublin, and 397 individuals availed of these services in 2014. Both services provide a safe and stable environment for young people over 18 years of age who wish to stabilise their problematic drug use.

Participants on the Stabilisation Programme engage in psycho-educational and process groups, with the aim of increasing drug and health awareness. This is achieved through ongoing peer-to-peer and one-to-one support.

The Swords Stabilisation Programme, which PMVT established in mid-2013, provides participants with access to two day programmes: an early relapse prevention programme, and the stabilisation programme. During its first full year, the new facility worked with over 100 people from the North Dublin area. The service provides links to other service providers in the region and is partly funded by the North Dublin Regional Drug and Alcohol Task Force.

For further information on the Peter McVerry Trust and the services it offers please access www.pmvtrust.ie

(Vivion McGuire)

1 Peter McVerry Trust (2015) *Annual report for 2014*. Dublin: PMVT. http://www.drugsandalcohol.ie/24829/

EMCDDA update

European conference on addictive behaviours and dependencies

The first European conference on addictive behaviours and dependencies was held in Lisbon on 23–25 September 2015. It was jointly organised by the Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the journal *Addiction*, and the International Society of Addiction Journal Editors (ISAJE). The conference was organised around four general themes:

- Addictions: a multi-disciplinary perspective
- Translating research into policy and practice
- New frontiers in addiction research
- Challenges of addiction in an interconnected world

Over 600 participants, including researchers, practitioners and policy experts from 58 countries and a range of specialist areas including illicit drugs, alcohol, tobacco, gambling and other addictive behaviours, attended the event. Research was presented in a number of developing fields such as new psychoactive substances, online sales and gambling, cannabis legalisation and alcohol pricing. Following on from the success of this conference it is planned that the next European conference will be held in Lisbon in 2017. *(Deirdre Mongan)*

Presentations and e-posters from the conference available at www.lisbonaddictions.eu/start#downloads

Prevention of addictive behaviours

The latest volume in the EMCDDA Insights series and released ahead of Lisbon Addictions 2015, *Prevention of addictive behaviours* updates a previous edition *Prevention of substance abuse*, published in 2008. Both editions are based on a German study commissioned by the Federal Centre for Health Education (Cologne) and present a state-of-the-art review of prevention science. Although originally targeted at a German audience, the evidence base addressed is global in scope. The review is broad in its considerations, covering not only the central topic of drug abuse, but also alcohol, tobacco and behavioural addictions, such as gambling.

Available in English at www.emcdda.europa.eu/publications/insights/preventing-addictive-behaviours

EMCDDA 20 years on

In 2015 the EMCDDA commemorated 20 years of monitoring the drugs problem in Europe. To mark the occasion, the agency has published a flyer presenting a brief summary of the agency's key achievements since 1995. Over the last two decades, much has changed in the extent and nature of the drug phenomenon and the Centre's work has developed to keep pace with this complexity. The text is complemented by an illustrative timeline highlighting a selection of major events presented by year.

Available in English at www.emcdda.europa.eu/publications/brochures/20-years

From *Drugnet Europe*

Lisbon Addictions 2015 – conference

'Addiction science in Europe is of growing policy relevance, becoming more mature in respect to capacity and quality and more influential in respect to its findings. Despite this, no multidisciplinary forum has existed until now to allow scientists working in the addictions area to share knowledge, to network and to present their latest findings...Now is a unique moment to establish a leading international forum on addictions'. These were the words of João Goulão, Director of the Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), at the opening of the first European conference on addictive behaviours and dependencies — Lisbon Addictions 2015 — held in the Portuguese capital from 23–25 September.

Hosted by SICAD, the event was held in collaboration with: the scientific journal Addiction; the International Society of Addiction Journal Editors; and the EMCDDA. State Secretary to the Portuguese Ministry of Health, Fernando Leal Da Costa, officially opened the conference. The European Commission was represented by Floriana Sipala (DG HOME) and Philippe Roux (DG SANTE). In his opening speech, EMCDDA Director Wolfgang Götz declared: 'Lisbon Addictions is a milestone for the European and international scientific community in the substance use and addiction field. In Europe, this is the first time that such a large multidisciplinary and cross-cutting event in this field has been organised and the EMCDDA is proud to be one of the main partners associated with making this possible'.

Showcasing the latest developments in addiction science, the conference explored the topics of illicit drugs, alcohol, tobacco, gambling and other addictive behaviours. Researchers, practitioners and policy experts participated from 58 countries. … Addressing the closing session, EMCDDA Scientific Director Paul Griffiths said: 'This conference has exposed us to the cutting-edge of new science occurring across the addictions field and has enabled us to forge new relationships from which, undoubtedly, many future collaborations will be born'. In his closing address, Deputy Director of SICAD Manuel Cardoso called for a 'broad, global and integrated perspective on problems and responses in the field of addictive behaviours and dependencies'. He ended announcing the second European conference on addictive behaviours and dependencies, to be held in Lisbon in 2017.

For more, see www.lisbonaddictions.eu and www.youtube.com/watch?v=ApQwlilCfNE

EMCDDA signs MoU with Georgian Ministry of Justice

The EMCDDA and Georgia are set to cooperate more closely on monitoring the drug phenomenon, following a Memorandum of Understanding (MoU) signed on 4 November in Tbilisi between the agency and the Georgian Ministry of Justice. The signatories were EMCDDA Director Wolfgang Götz and the Georgian Minister of Justice Tea Tsulukiani. The two bodies recognise that information on the drug phenomenon is an essential and indispensable instrument for drafting and implementing drug policies and for assessing the impact of actions to reduce problems originating from drug use and trafficking. The MoU provides for the: exchange of technical expertise and knowledge between the two institutions; co-sponsoring of technical meetings; and the pooling of human and financial resources to launch joint programmes. The agreement will be implemented through a joint work programme to be updated every three years. This is the fifth MoU to be signed between the EMCDDA and a country of the European Neighbourhood Policy area: agreements already exist with Armenia, Israel, Moldova and Ukraine.

For more, see Fact sheet No 9/2015 at www.emcdda.europa.eu/news/2015/fs9/georgian-memorandum-of-understanding

Malta's new drug law focuses on helping users

A new 'Drug Dependence (Treatment not Imprisonment) Act' entered into force in Malta on 15 April, significantly changing the country's legal framework for responding to drug use and drug-related crime. In introducing the Act, the Maltese government provides for the treatment of persons in possession of small quantities of prohibited drugs for personal use and, for some drug-related crimes, for the rehabilitation of persons suffering from drug dependence.

Prior to the legislation, the Magistrate's Court could issue a penalty of 3–12 months' imprisonment and/or a fine for possession of drugs for personal use. Now, the Commissioner for Justice should issue an administrative penalty of EUR 50–100 for the possession of under 3.5 g of cannabis or of EUR 75–125 for under 2 g of other drugs (provided that there is no evidence of supply).

A repeat offender possessing a drug other than cannabis will appear before the new Drug Offenders Rehabilitation Board, which may take various measures to help the offender recover from dependence. The Board is chaired by a retired judge or magistrate and has three members appointed by the Ministers of Home Affairs, Social Policy and Health respectively. The Magistrate's Court, supported by the Board, may decide to assume the functions of a Drugs Court in defined cases (e.g. dependent offender, some drug-related crimes). Here it may refer the offender to the Board, which would, in turn, manage the offender for up to 18 months in recovering from dependence. After this, the case may be closed, or prosecution continued, accordingly.

The Act also establishes: the removal of mandatory imprisonment for the cultivation of one cannabis plant for personal use; a Sentencing Policy Advisory Board (which aims to achieve consistency in court punishments for drug-related offences); a legal basis for the prescription of licensed medical preparations of cannabis; and an exemption from prosecution for drug possession for anyone assisting a person suffering from drug overdose

For more, see https://mjcl.gov.mt/en/justice/Pages/Drug-Dependence Act.aspx

Europe responds to health concerns posed by new psychoactive substances

Europe has responded to rising concerns over the use of two new drugs by subjecting them to control measures and criminal penalties throughout the Union. The implementing decision of the Council of the EU (1) was adopted on 8 October, in the final stage of the three-step legal procedure designed to respond to potentially threatening new

From *Drugnet Europe (continued)*

psychoactive substances (NPS) available on the market (2). The two new substances — 4,4'-DMAR (a derivative of aminorex with psychostimulant properties) and MT-45 (a synthetic opioid investigated in the 1970s for its analgesic properties) — have been raising health concerns in Europe after harmful effects related to them were reported by the Member States through the EU Early Warning System (EWS)(3). On 18 November, an extended EMCDDA Scientific Committee will meet in Lisbon to undertake the risk assessment of a new psychoactive cathinone currently detected in over 100 serious adverse events in Europe. The substance in question, the stimulant drug α-PVP, is the third cathinone to be risk assessed by the agency (4). The EMCDDA has also issued early-warning alerts on acetylfentanyl, a new potent synthetic opioid with analgesic properties, after it was linked to serious harms in the EU. Concern over this fentanyl has led the EWS to launch a data-collection exercise on this substance. This will lead to the preparation of an EMCDDA–Europol Joint report, due in December 2015 (5).

(1) Council implementing decision (2015/1873) published in the Official Journal of the European Union on 20.10.2015. For more, see news release No 9/2015 at www.emcdda.europa.eu/news/2015/9/44-dmar-and-mt-45
(2) Council Decision 2005/387/JHA. For more, see www.emcdda.europa.eu/activities/action-onnew-drugs
(3) Risk assessment reports on the two substances are available at www.emcdda.europa.eu/publications/risk-assessments
(4) Joint report available at www.emcdda.europa.eu/publications/joint-reports/alpha-pvpUpcoming risk assessment report at www.emcdda.europa.eu/publications/risk-assessments
(5) Upcoming Joint report at www.emcdda.europa.eu/publications/joint-reports

Minimum quality standards in drug demand reduction

The EU Council of Ministers (General Affairs Council) adopted on 14 September 'Minimum quality standards in drug demand reduction in the EU'. This innovative initiative lists 16 standards which represent a minimum quality benchmark for interventions in: drug use prevention; risk and harm reduction; treatment; social integration and rehabilitation. The standards are the result of work carried out under three consecutive EU presidencies (Greece, Italy, Latvia) between January 2014 and June 2015. They were drawn up in the context of Action 9 of the EU action plan on drugs (2013–16), which calls on the Council, Commission, Member States and the EMCDDA 'to agree and commence implementation of EU minimum quality standards' in demand reduction. Although non-binding for national governments, these standards represent solid political will in the EU to address drug demand reduction through an evidence-based perspective. The EMCDDA is invited in the document 'to continue gathering evidence on effective interventions and services in drug demand reduction and provide Member States with technical support and expertise in the implementation of these standards'. It is disseminating the standards via its Best Practice portal. The newly adopted standards represent a major development in drug policy formulation at EU level, bridging expert knowledge and political decision-making across 28 countries.

For more, see www.emcdda.europa.eu/news/2015/eu-minimum-

Recent publications

The following abstracts are cited from recently published journal articles relating to the drugs situation in Ireland.

The challenge of opioid-induced hyperalgeisa

Calami A and Dowdall D (2015) *Forum* 32 (11): 39–42
http://www.drugsandalcohol.ie/24915/

Long-term exposure to opiates or synthetic opioids has been shown to sensitise subjects to painful stimuli. This is of significance in the areas of chronic pain management (as patients receiving opioid analgesia can actually become more sensitive to pain) and in managing acute and chronic pain in people on the methadone replacement programme for addiction to opiates.

'Codeine is my companion': misuse and dependence on codeine containing medicines in Ireland

Van Hout MC, Horan A, Santlal K, Rich E and Bergin, M (2015) *Irish Journal of Psychological Medicine* Early online
http://www.drugsandalcohol.ie/24912/

Global concern around over-the-counter availability of codeine-containing products and risk of misuse, dependence and related harms are evident. A phenomenological study of lived experiences of codeine misuse and dependence was undertaken in Ireland, following the Pharmaceutical Society of Ireland's 2010 guidelines for restricted supply of non-prescription codeine containing products.

In-depth interviews were conducted with a purposive sample of adult codeine misusers and dependents (n=21), both actively using, in treatment and in recovery. The narratives were analysed using the Empirical Phenomenological Psychological five-step method (Karlsson, 1995). A total of 10 themes with 82 categories were identified. Two concepts at a higher level of abstraction above the theme-level emerged during the final stage of analysis. The concepts identified were 'emotional pain and user self-legitimization of use' and 'entrapment into habit-forming and invisible dependent use'. These concepts were reported in different ways by a majority of participants.

Findings are presented under the following themes: (1) profile and product preferences; (2) awareness of habit forming use and harm; (3) negotiating pharmacy sales; (4) alternative sourcing routes; (5) the codeine feeling; (6) the daily routine; (7) acute and chronic side effects; (8) social isolation; (9) withdrawal and dependence; and (10) help-seeking and treatment experiences.

There is a public health and regulatory imperative to develop proactive responses tackling public availability of codeine-

Recent publications *(continued)*

containing medicines, risk minimisation in consumer self-treatment for pain, enhanced patient awareness of potential for habit forming use and its consequences, and continued health professional pharmacovigilence.

Development and process evaluation of an educational intervention for overdose prevention and naloxone distribution by general practice trainees

Klimas J, Egan M, Tobin H, Coleman N and Bury G (2015) *BMC Medical Education* 15 (206)
http://www.drugsandalcohol.ie/24856/

Overdose is the most common cause of fatalities among opioid users. Naloxone is a life-saving medication for reversing opioid overdose. In Ireland, it is currently available to ambulance and emergency care services, but General Practitioners (GP) are in regular contact with opioid users and their families. This positions them to provide naloxone themselves or to instruct patients how to use it. The new Clinical Practice Guidelines of the Pre-hospital Emergency Care Council of Ireland allows trained bystanders to administer intranasal naloxone. We describe the development and process evaluation of an educational intervention, designed to help GP trainees identify and manage opioid overdose with intranasal naloxone.

Participants (N=23) from one postgraduate training scheme in Ireland participated in a one-hour training session. The repeated-measures design, using the validated Opioid Overdose Knowledge (OOKS) and Attitudes (OOAS) Scales, examined changes immediately after training. Acceptability and satisfaction with training were measured with a self-administered questionnaire.

Knowledge of the risks of overdose and appropriate actions to be taken increased significantly post-training [OOKS mean difference, 3.52 (standard deviation 4.45); $P<0.001$]; attitudes improved too [OOAS mean difference, 11.13 (SD 6.38); $P<0.001$]. The most and least useful delivery methods were simulation and video respectively.

Appropriate training is a key requirement for the distribution of naloxone through general practice. In future studies, the knowledge from this pilot will be used to inform a train-the-trainer model, whereby healthcare professionals and other front-line service providers will be trained to instruct opioid users and their families in overdose prevention and naloxone use.

Effectiveness of a multifaceted intervention for potentially inappropriate prescribing in older patients in primary care: A cluster-randomized controlled trial (OPTI-SCRIPT study)

Clyne B, Smith SM, Hughes CM, Boland F, Bradley M, Cooper JA and Fahey T (2015) *Annals of Family Medicine* 18 (6): 545–553
http://www.drugsandalcohol.ie/24781/

Potentially inappropriate prescribing (PIP) is common in older people and can result in increased morbidity, adverse drug events, and hospitalizations. The OPTI-SCRIPT study (Optimizing Prescribing for Older People in Primary Care, a cluster-randomized controlled trial) tested the effectiveness of a multifaceted intervention for reducing PIP in primary care. We conducted a cluster-randomized controlled trial among 21 general practitioner practices and 196 patients with PIP. Intervention participants received a complex, multifaceted intervention incorporating academic detailing; review of medicines with web-based pharmaceutical treatment algorithms that provide recommended alternative-treatment options; and tailored patient information leaflets. Control practices delivered usual care and received simple, patient-level PIP feedback. Primary outcomes were the proportion of patients with PIP and the mean number of potentially inappropriate prescriptions. We performed intention-to-treat analysis using random-effects regression.

All 21 practices and 190 patients were followed. At intervention completion, patients in the intervention group had significantly lower odds of having PIP than patients in the control group. The mean number of PIP drugs in the intervention group was 0.70, compared with 1.18 in the control group ($P = .02$). The intervention group was almost one-third less likely than the control group to have PIP drugs at intervention completion, but this difference was not significant. The intervention was effective in reducing proton pump inhibitor prescribing.

The OPTI-SCRIPT intervention incorporating academic detailing with a pharmacist, and a review of medicines with web-based pharmaceutical treatment algorithms, was effective in reducing PIP, particularly in modifying prescribing of proton pump inhibitors, the most commonly occurring PIP drugs nationally.

Clustering of sex and substance use behaviors in adolescence

McAloney K (2015) *Substance Use & Misuse* Early online
http://www.drugsandalcohol.ie/24644/

Adolescents often experiment with substance use and sexual activity, which can impact upon their health and well-being, and establish harmful patterns of behavior which continue into adulthood. While substance use and participation in sexual behaviors often co-occur, few studies have examined whether these behaviors cluster in adolescence.

Alcohol consumption was the most prevalent risk behavior (75%), followed by cigarette smoking, sexual intercourse, illicit substance use, and solvent use the least prevalent. Over 40% of young people participated in multiple risk behaviors (2 or more). Several behavior combinations were statistically clustered, for most the reported prevalence was lower than expected, however, participation in all five risk behaviors occurred at a much higher rate than expected, particularly for male youth.

While experimentation with risky behaviors is often considered developmentally appropriate in adolescence it is important to understand how young people experience these behaviors, and the potential for multiple risk exposures as a result of participation in substance use and sexual behaviors. These findings highlight the clustering of substance use and sexual behaviors, and indicate variations in vulnerability to participation in multiple risk behaviors by gender.

Socioeconomic inequalities in the impact of tobacco control policies on adolescent smoking. A multilevel study in 29 European countries

Pförtner T-K, Hublet A, Schnohr CW, Rathmann K, Moor I, de Looze M, Baška T, Molcho M, Kannas L, Kunst AE and Richter M (2015) *Addictive Behaviors* 53: 58–66
http://www.drugsandalcohol.ie/24618/
Data were used from the Health Behaviour in School-aged Children (HBSC) study conducted in 2005/2006 comprising 50,338 adolescents aged 15 years from 29 European countries.

Recent publications *(continued)*

Multilevel logistic regression analyses were conducted to assess the association of weekly smoking with components of the Tobacco Control Scale (TCS), and to assess whether this association varied according to family affluence (FAS). Analyses were carried out per gender and adjusted for national wealth and general smoking rate.

Results indicated that most tobacco control policies are not clearly related to adolescent weekly smoking across European countries. Only tobacco price seemed to be adequate decreasing smoking prevalence among boys, irrespective of their socioeconomic status.

Personality and substance use: psychometric evaluation and validation of the Substance Use Risk Profile Scale (SURPS) in English, Irish, French, and German adolescents

Jurk S et al. (2015) *Alcoholism Clinical and Experimental Research,* Early online
http://www.drugsandalcohol.ie/24665/

The aim of the present longitudinal study was the psychometric evaluation of the Substance Use Risk Profile Scale (SURPS).

We analyzed data from N = 2,022 adolescents aged 13 to 15 at baseline assessment and 2 years later (mean interval 2.11 years). Missing data at follow-up were imputed (N = 522). Psychometric properties of the SURPS were analyzed using confirmatory factor analysis. We examined structural as well as convergent validity with other personality measurements and drinking motives, and predictive validity for substance use at follow-up.

The hypothesized 4-factorial structure (i.e., anxiety sensitivity, hopelessness, impulsivity [IMP], and sensation seeking [SS]) based on all 23 items resulted in acceptable fit to empirical data, acceptable internal consistencies, low to moderate test-retest reliability coefficients, as well as evidence for factorial and convergent validity. The proposed factor structure was stable for both males and females and, to lesser degree, across languages. However, only the SS and the IMP subscales of the SURPS predicted substance use outcomes at 16 years of age.

The SURPS is unique in its specific assessment of traits related to substance use disorders as well as the resulting shortened administration time. Test-retest reliability was low to moderate and comparable to other personality scales. However, its relation to future substance use was limited to the SS and IMP subscales, which may be due to the relatively low-risk substance use pattern in the present sample.

Vulnerable families and drug use: examining care admissions of children of parents attending an Irish drug treatment facility

McGivern A and McDonnell C (2015) *The Irish Social Worker* (Spring): 17–23
http://www.drugsandalcohol.ie/24712/

Harmful substance use has a detrimental effect on parenting and child welfare agencies consistently confirm such usage as a primary factor in initial referral. This article examines the circumstances of child admissions to care over a nine year period, from families where one or both parents attend a centralized drug treatment services. A recurrent theme during the study period was low rates of family reunifications within a twelve month period. Furthermore, we identified factors which in the view of natural parents and the service social work team have contributed significantly when families have been reunited.

Low resolution and high resolution MS for studies on the metabolism and toxicological detection of the new psychoactive substance methoxypiperamide (MeOP)

Meyer MR, Holderbaum A, Kavanagh P and Maurer HH (2015) Journal of Mass Spectrometry 50 (10): 1163–74
http://www.drugsandalcohol.ie/24617/

In 2013, the new psychoactive substance methoxypiperamide (MeOP) was first reported to the European Monitoring Centre for Drugs and Drug Addiction. Its structural similarity to already controlled piperazine designer drugs might have contributed to the decision to offer MeOP for online purchase.

The aims of this work were to identify the phase I/II metabolites of MeOP in rat urine and the human cytochrome P450 (CYP) isoenzymes responsible for the initial metabolic steps. Finally, the detectability of MeOP in rat urine by gas chromatography-mass spectrometry (GC-MS) and liquid chromatography coupled with multistage mass spectrometry (LC-MS(n)) standard urine screening approaches (SUSAs) was evaluated. After sample preparation by cleavage of conjugates followed by extraction for elucidating phase I metabolites, the analytes were separated and identified by GC-MS as well as liquid chromatography-high resolution-tandem mass spectrometry (LC-HR-MS/MS). For detection of phase II metabolites, the analytes were separated and identified after urine precipitation followed by LC-HR-MS/MS. The following metabolic steps could be postulated: hydrolysis of the amide, N-oxide formation, N- and/or O-demethylation, oxidation of the piperazine ring to the corresponding keto-piperazine, piperazine ring opening followed by oxidation of a methylene group to the corresponding imide, and hydroxylation of the phenyl group. Furthermore, N-acetylation, glucuronidation and sulfation were observed.

Using human CYPs, CYP1A2, CYP2C19, CYP2D6, and/or CYP3A4 were found to catalyze N-oxide formation and N-, O-demethylation and/or oxidation. Mostly MeOP and N-oxide-MeOP but to a minor degree also other metabolites could be detected in the GC-MS and LC-MS(n) SUSAs.

Examining the use of community service orders as alternatives to short prison sentences in Ireland

O'Hara K and Rogan M (2015) *Irish Probation Journal,* 12 http://www.drugsandalcohol.ie/24883/

Ireland's highly discretionary sentencing system provides a rare opportunity to study the behaviour of judges when relatively free of externally imposed constraints. While this is so, few studies have investigated sentencing trends. In 2011, Ireland introduced the Criminal Justice (Community Service) (Amendment) Act 2011 requiring courts to consider imposing Community Service Orders (CSOs) in cases where sentences of less than twelve months are deemed appropriate. A CSO is a direct prison alternative requiring offenders to complete between forty and 240 hours unpaid community work in lieu of a prison term. In order to complete comparative analysis, administrative data pertaining to all cases sentenced to a short term of imprisonment or CSO between 2011 and 2012 were linked and analysed. Analysis of offence groups showed that more cases convicted of drug, public order, and robbery or related offences received Community Service

Recent publications *(continued)*

than was expected; however effect sizes were small. Findings showed the average number of Community Service hours equivalent to one month of imprisonment differed by offence type and District Court jurisdiction. As the first of its kind in Ireland, this study provides a rare glimpse of the use of these two alternative criminal justice sanctions. Findings and their implications are discussed.

Coolmine Therapeutic Community, Dublin: a forty-year history of Ireland's first voluntary drug treatment service

Butler S (2015) *Addiction* Early online
http://www.drugsandalcohol.ie/24509/

To document the evolution over forty years (1973–2013) of Coolmine Therapeutic Community (Ireland's first voluntary drug treatment service) against a background of broader drug policy developments in the Republic of Ireland and elsewhere during this period, data were gathered by means of archival research within Coolmine, complemented by semi-structured interviews with former clients, current and former Coolmine management and staff, and representatives of outsider stakeholder interests.

Coolmines's history has three phases: (1) an early and uncontentious phase in which external authorities provided financial support for Coolmine without questioning its work practices or outcomes; (2) a middle, controversial phase in which Coolmine struggled for survival in an external policy environment now dominated by harm reduction strategies; and (3) a final phase in which, through the use of conventional corporate governance, Coolmine management sought to repair its damaged reputation by introducing evidence-based clinical practices.

Coolmine Therapeutic Community was established when drug treatment services in Ireland were in their infancy, and its changing fortunes over subsequent decades reflected changing perceptions of what constitutes appropriate addiction treatment – and in particular the role to be played by former addicts within addiction treatment systems – as well as changing perceptions of funding relationships between statutory authorities and voluntary providers of health and social services.

The drug situation in Europe: an overview of data available on illicit drugs and new psychoactive substances from European monitoring in 2015

Mounteney J, Griffiths P, Sedefov R, Noor A, Vicente J and Simon R (2015) *Addiction* Early online
http://www.drugsandalcohol.ie/24570/

A central task for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is to produce an annual report of the latest data available on drug demand and drug supply in Europe. This paper is intended to facilitate a better understanding of, and easier access to, the main quantitative European level data sets available in 2015.
The European reporting system formally covers all 28 European Union (EU) Member States, Norway and Turkey and incorporates multiple indicators alongside an early warning system (EWS) on uncontrolled new psychoactive substances (NPS). While epidemiological information is based largely on registries, surveys and other routine data reported annually, the EWS collects case-based data on an ongoing basis. The 2015 reporting exercise is centred primarily on a set of standardized reporting tools.

The most recent data provided by European countries are presented, including data on drug use, drug-related morbidity and mortality, treatment demand, drug markets and new psychoactive substances, with data tables provided and methodological information. A number of key results are highlighted for illustrative purposes. Drug prevalence estimates from national surveys since 2012 (last year prevalence of use among the 15-34 age band) range from 0.4% in Turkey to 22.1% in France for cannabis, from 0.2% in Greece and Romania to 4.2% in the United Kingdom for cocaine, from 0.1% in Italy and Turkey to 3% in the Czech Republic and the United Kingdom for ecstasy, and from 0.1% or less in Romania, Italy and Portugal to 2.5% in Estonia for amphetamine. Declining trends in new HIV detections among people who inject drugs are illustrated, in addition to presentation of a breakdown of NPS reported to the EU early warning system, which have risen exponentially from fewer than 20 a year between 2005 and 2008, to 101 reported in 2014.

Structured information is now available on patterns and trends in drug consumption in Europe, which permits triangulation of data from different sources and consideration of methodological limitations. Opioid drugs continue to place a burden on the drug treatment system, although both new heroin entrants and injecting show declines. More than 450 new psychoactive substances are now monitored by the European early warning system with 31 new synthetic cathinones and 30 new synthetic cannabinoid receptor agonists notified in 2014.

Alcohol consumption and cardiovascular disease, cancer, injury, admission to hospital, and mortality: a prospective cohort study

Smyth A et al. (2015) *Lancet*
http://www.drugsandalcohol.ie/24524/

Alcohol consumption is proposed to be the third most important modifiable risk factor for death and disability. However, alcohol consumption has been associated with both benefits and harms, and previous studies were mostly done in high-income countries. We investigated associations between alcohol consumption and outcomes in a prospective cohort of countries at different economic levels in five continents.

We included information from 12 countries participating in the Prospective Urban Rural Epidemiological (PURE) study, a prospective cohort study of individuals aged 35-70 years. We used Cox proportional hazards regression to study associations with mortality (n=2723), cardiovascular disease (n=2742), myocardial infarction (n=979), stroke (n=817), alcohol-related cancer (n=764), injury (n=824), admission to hospital (n=8786), and for a composite of these outcomes (n=11 963).

We included 114 970 adults, of whom 12 904 (11%) were from high-income countries (HICs), 24 408 (21%) were from upper-middle-income countries (UMICs), 48 845 (43%) were from lower-middle-income countries (LMICs), and 28 813 (25%) were from low-income countries (LICs). Median follow-up was 4·3 years (IQR 3·0-6·0). Current drinking was reported by 36 030 (31%) individuals, and was associated with reduced myocardial infarction (hazard ratio [HR] 0·76 [95% CI 0·63-0·93]), but increased alcohol-related cancers (HR 1·51 [1·22-1·89]) and injury (HR 1·29 [1·04-1·61]). High intake was associated with increased mortality (HR 1·31 [1·04-1·66]). Compared with never drinkers, we

Recent publications *(continued)*

identified significantly reduced hazards for the composite outcome for current drinkers in HICs and UMICs (HR 0·84 [0·77-0·92]), but not in LMICs and LICs, for which we identified no reductions in this outcome (HR 1·07 [0·95-1·21]; pinteraction<0·0001).

Current alcohol consumption had differing associations by clinical outcome, and differing associations by income region. However, we identified sufficient commonalities to support global health strategies and national initiatives to reduce harmful alcohol use.

Upcoming events

March 2016

22–23 March 2016
Marijuana and cannabinoids: a neuroscience research summit
Venue: Natcher Conference Center, Building 45, NIH campus, Bethesda, Maryland, USA
Organised by: National Institutes of Health (NIH)
Further information: http://apps1.seiservices.com/nih/mj/2016/

The conference will focus on the neurological and psychiatric effects of marijuana, other cannabinoids, and the endocannabinoid system. Both the adverse and the potential therapeutic effects of the cannabinoid system will be discussed. The goal to ensure evidence-based information is available to inform practice and policy, particularly important at this time given the rapidly shifting landscape regarding the recreational and medicinal use of marijuana.

April 2016

19–21 April 2016
United Nations General Assembly Special Session on the World Drug Problem (UNGASS 2016)
Venue: UN Headquarters, New York, USA
Organised by: Department of General Assembly and Conference Management
Further information: http://www.unodc.org/ungass2016/en/about.html

The Special Session will be an important milestone in achieving the goals set in the policy document of 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, which defined action to be taken by member states as well as goals to be achieved by 2019.

Member states, UN entities and specialised agencies, intergovernmental organisations, as well as NGOs accredited to participate in the Special Session, are being given the opportunity to hold side events. Starting on 18 April and running concurrently with the Special Session, these side events will be on topics thematically relevant to the UNGASS.

Johnny Connolly

Dr Johnny Connolly has left the HRB after 13 years working on drug-related crime and markets indicators for the Irish EMCCDA focal point.

During his time with the HRB Johnny completed a number of pieces of research. His most notable achievement was the first ever study of illicit drug markets in Ireland, which was published in 2014.

Johnny will shortly leave Dublin to live in the Cloughjordan ecovillage in North Tipperary and we wish him and his family well in this big move.

May 2016

16–18 May 2016
10th Annual Conference of the International Society for the Study of Drug Policy (ISSDP)
Venue: Q Station, North Head Scenic Drive, Manly NSW 2095, Australia
Organised by: Drug Policy Modelling Program (DPMP), National Drug and Alcohol Research Centre (NDARC), UNSW Australia
Further information: http://www.issdp2016.com/

The aims of the ISSDP conference are to:

- present original scientific research on drug policy;
- create opportunities for vigorous discussion and debate about findings and methods;
- provide an environment conducive for networking and the establishment of new collaborations;
- provide a stimulus for delegates to publish their work in journals; and
- inform policy makers about the latest scientific evidence underpinning drug policy.

In showcasing Australia, New Zealand and our region, the conference themes include:

- Harm reduction: old, new and emerging forms of harm reduction
- Drugs policy and its intersection with human rights and development
- Indigenous peoples and illicit drug policy
- Drug markets and policy responses in Australia, New Zealand and Asia Pacific
- Drug user groups and drug policy: the role of consumers and other stakeholders

In addition to these themes, we are also aware of the international drug policy stage, with the UN General Assembly Special Session (UNGASS) on drugs in April 2016. The conference will include analysis of international drug policy reforms, the international drug control system and analysis of the event itself.